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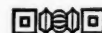
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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—6TH YEAR.

SYDNEY: SATURDAY, APRIL 5, 1919.

No. 14.

An Address.¹

By A. A. Palmer, M.B., M.S. (Edin.), F.R.C.S. (Edin.),
President of the New South Wales Branch of the British
Medical Association.

We are finishing the year under much happier circumstances than we began it. Then we were engaged in a bloody war which was not going favourably with us; now we are concluding a victorious and, we trust, a satisfactory peace which should last for generations. This Branch has already had the privilege of welcoming home a few of our returned members and in the near future we hope to have an opportunity of greeting the rest.

It is with great regret that I have to report that death has been busy amongst our members during the year. We have lost on active service Dr. J. B. Metcalfe (died of wounds, April 25, 1918), Dr. R. A. Sillar (died on service, June 30, 1918), Dr. J. S. Wilson (died of wounds, August 19, 1918), Dr. H. E. Kirkland (killed in action, October 30, 1918); and at home Dr. R. Dey, Dr. T. W. Francis, Dr. R. Ferguson, Sir Philip Sydney Jones, Dr. E. H. Bottrell, Dr. S. L. Richardson, Dr. J. McLeod, Dr. H. C. S. Warren, Dr. G. Bowen Thomas, Dr. J. K. Freyer, Dr. Noel H. Franki and Dr. J. P. Clifford.

The year has been a busy one for many of us. The work of this Branch grows rapidly year by year and serving on the Council is no longer a sinecure. This you may to some extent understand by looking at the list of standing committees and their frequent meetings.

Having more or less finished with the war, this country has been attacked by pestilence, termed at present pneumonic influenza. Fortunately, although maintaining a fairly high death-rate, the disease for long did not spread with the rapidity seen in New Zealand and other countries. I am not going to argue as to the cause of this. It may have been due to our climate, to one or more of the many precautions taken, or to a combination of them. I wish chiefly to refer to the fact that for the first time in our history, the Commonwealth and State Governments fully recognized and called to their aid the British Medical Association. This is only right and proper and we can only trust that the pleasant relations now existing between our rulers and the medical profession will continue.

It is interesting to note that in Great Britain in the scheme for a Ministry of Health, great stress was laid by the medical profession upon the appointment of an advisory board or consultative council to advise the Minister. As far as one can judge by the cabled accounts of the Bill this was done.

Our help has been given wholeheartedly and ungrudgingly and has been warmly received. It is true that certain people have been so keenly arguing about the strict letter of an agreement that they, for a time,

departed from the spirit of it. It is true also that in this State there has been some carping criticism of the measures recommended by the Consultative Council. Perhaps, on the old idea of doctors disagreeing, this was only what was to be expected. Apparently these critics were unable to realize that the members of the Council gave their time unsparingly for the benefit of the community and in all their actions had only that end in view.

Having said nice about the idea of a Consultative Council, I must now admit that there may be a reverse side. A Government might use the Council as a shelter or "scapegoat." This might be done by unduly deferring or restricting consultation or by adopting only part of the Council's recommendations and leaving the press and public in ignorance of the fact.

The medical profession must not lose its independence, and any council of its members must retain initiative of advice. It is fully recognized that the ultimate decision must rest with the Government, but where it departs to any extent from the recommendations of the Council, unless such departure is known to the profession and public, it is obvious that the Council may meet with much undeserved criticism.

In England, to avoid that the advisory council should be used as mere "window dressing," it was recommended that it should have the power to report direct to Parliament. Although the Consultative Council is not on the same footing, it is not too much to ask that any departure as above should be made public, if not in a particular, then in a general, statement from the Minister or Premier.

One matter which has given your Council great concern is the question of the future of the medical profession. This is apparently the chief matter of interest to medical men in Great Britain. Many schemes have been put forward, some of them Utopian and nearly all, in my opinion, either impracticable or likely to be disastrous in their effect on the medical profession; and that which is disastrous to the profession, cannot be good for the public.

The best scheme put forward is perhaps the official one of the British Medical Association in the United Kingdom, but much of it is, I think, unsuitable for Australia.

Judging by what has appeared in the *British Medical Journal*, it appears to be assumed that a demand for a change is to emanate from those medical men who have served their country in the war. The idea, as far as I can gather, seems to be that these men have become so accustomed to work under constituted authority and for a regular and assured income that they will shirk the open competition of general practice and will support straight out nationalization. To me, it hardly seems feasible that men who have faced so much and shown so much enterprise, are going to do any such thing.

Another matter which appears to have stirred the public and politicians to greater interest in this

¹ Delivered at the Annual Meeting of the New South Wales Branch of the British Medical Association on March 28, 1919.

question was the discovery that such a large proportion of the men and women of Great Britain were medically unfit for the work of the Great War. The deduction by them is seemingly that given cheap or free medical attendance all this would be altered, a conclusion eminently flattering to the medical profession.

The *British Medical Journal* dealing with this matter stated that the chief factors concerned in producing this mass of physical inefficiency were too little food and fresh air, too little play, too little comfort in the homes, too long hours of work and too little sleep, whilst Dr. Christopher Addison said: "Improved national physique would depend on better homes and habits, better work places and conditions of life generally."

Furthermore, it has been said that the conduct of the war has been an argument in favour of the nationalization of almost everything. Many of us think quite the opposite; that England muddled along from bad to worse until she called to her aid the great captains of industry—Pirie, Weir, Rhondda, Geddes and scores of others of a brand Government Service does not encourage—who made order out of chaos. I am not suggesting that nationalization of the profession is impracticable, but the day of its introduction would be a bad day not only for the profession but for the public. Even Dr. Addison, who has been suspected by some of leanings in this direction, stated: "that the public interest in the long run would suffer if an attempt were made to promote it by exploiting the services of a class."

Nationalization of the profession would check individual enterprise, substitute intrigue and influence for merit and in general hinder medical progress. Governments never hold out sufficient inducements to obtain as servants the best intellects of the community and probably never will; and should nationalization be accomplished, it is as certain as night follows the day that the status and efficiency of the profession will be lowered.

The Federal Committee in its pronouncement of February, 1918, laid it down that the interests of the public were best served by the members of the profession continuing to conduct their practices as free individual citizens in competition with one another and that a third party intervention between medical attendant and patient is in every way undesirable. The profession stands to that. There is, however, plenty of scope for the extension of the State services and suggestions to that end have been considered by your Council, and its conclusions forwarded to the Federal Committee.

Most of the schemes put forward as substitutes for nationalization lay great stress on improving the conditions of work and the status of the general practitioner. It has been recognized that one of his greatest handicaps at present is that he is unable to follow his patients into hospital, but has to surrender them to the care of the select few on the honorary staffs of the hospitals.

The scheme already referred to, of the British Medical Association in the United Kingdom, suggests that the principle embodied in the system exemplified in most cottage hospitals might be largely extended,

as this system, to a large extent, allows the family doctor to follow his patients into the hospital. It is not suggested that all large hospitals should be abolished. Some few are, no doubt, necessary in large centres of population—for the training of medical students, the better carrying out of certain specialties and for other reasons. But the principle above mentioned if largely extended would, it is claimed, be of great advantage to all concerned. With this suggestion I am in full accord and consider that Governments would do more good to the public and profession by working in this direction, than by increasing the number of large hospitals which, apart from other drawbacks, must be comparatively inaccessible to medical men, the patients and the patients' friends.

There are other important matters which could be discussed but I leave them for other times and other people. No doubt there are critical times ahead and it behoves the profession to be united and prepared.

It now only remains for me to thank you for putting me in this position of honour. Although the work is exacting and trying, I have enjoyed it. I have had with me a keen business-like Council, the members of which have shown me great forbearance and given me every assistance, whilst, as usual, the brunt of the work has fallen upon the Honorary Secretary.

ON THE IMPORTANCE OF DE-IONIZATION IN THE TREATMENT OF PLUMBISM IN QUEENSLAND CHILDREN.¹

By J. Lockhart Gibson, M.D. (Edin.), M.R.C.S. (Eng.),
Honorary Ophthalmologist, Hospital for Sick Children,
Brisbane.

In 1902 a book called "Dangerous Trades" contained a chapter by Dr. H. Lewis Jones on the treatment of lead poisoning by means of single electric baths.

Sir Thomas Oliver's paper on the "Preventative and Curative Treatment of Industrial Lead Poisoning," published in August, 1913 (*Lancet*, August 23, 1913), indicated the treatment I am bringing to your notice to-night. Not even the war is sufficient excuse for allowing five years to elapse before putting the treatment to the test in Brisbane.

Oliver, to whom de-ionization by the two-bath system was suggested by Mr. Claque, a chemist, first put the treatment to the test in the case of a lead-poisoned laboratory rabbit. He next used it for the treatment of workers at white lead manufactories.

Essentially the apparatus consists of a hand bath or trough and a foot bath or trough. In each of these is a large aluminium plate. The aluminium plate in the foot bath is connected with the positive pole of a battery, the plate in the hand bath with the negative pole. The voltage he employed was 16 volts, and the amperage 20 to 40 milliampères. Both feet are placed on the aluminium plate in the foot bath and both hands on the aluminium plate (or negative pole) in the hand bath and the current turned on. The bath contains salt solution to cover the plates and the hands and feet. The bath is given for half an hour daily. The

¹ Read at a Meeting of the Queensland Branch of the British Medical Association on March 7, 1919.

treatment proved highly successful. He argued that by adopting the two-bath method the electric current passed through the whole body. It was found that lead in the case of lead workers was invariably deposited on the negative pole. The improvement in his patients mentioned was striking. His statement that the blue line in the gums, when it existed, always disappeared after a few baths, seemed to indicate that the current searched every nook and cranny of the body to find and eliminate lead from it. In fact, to accept his evidence meant to me that such treatment would free our numerous lead-poisoned children from lead more than it would be possible to do by any other means, that it would do away with the cases of relapsing leg and arm palsy in children, who were said by their parents to have been prevented from ingesting more lead after the symptoms had disappeared under treatment. Furthermore, that it would be most likely to prevent the cases of chronic nephritis in young adults, which so many of my Brisbane colleagues are attributing to the ingestion of lead when young children, and, consequently, to its incomplete elimination. We get some support for this contention regarding lead as a cause of nephritis from Sir Thomas Oliver's laboratory rabbits. One died after having received lead almost daily for three years. Twice during these three years it had recovered the use of its limbs under de-ionization, only to relapse on lead feeding being resumed. In its liver and kidneys there was found microscopically a distinct increase in connective tissue and lead was extracted from them. At Broken Hill the de-ionization apparatus has been in use for some time and has given good results.

Apparently lead becomes encysted or stored up in the body in some way parallel to the blue line in the gums and may be dealt out and become active for some reason which we do not yet grasp.

After Mr. Jackson, electrician, had erected a two-bath de-ionizing apparatus for me at the Children's Hospital, I first subjected to it a girl aged seven years, who had just recovered from a severe attack of ocular plumbism. I saw her first on November 7, 1918, when she was sent to me by Dr. Patterson, of Ipswich, with a recent paralytic squint of three weeks' standing and loss of sight. She had been treated from the time I sent her to the Hospital for Sick Children with four lumbar punctures, with intervals of three or four days, resulting first in 56 c.cm. (5 ii.) under considerable pressure, second in 28 c.cm. (5 i.), third in 14 c.cm. (3 ss.) and fourth in 7 c.cm. (5 ii.) of perfectly clear fluid, with dilute sulphuric acid and magnesium sulphate; and after the first week with 0.3 grm. (5 grs.) doses of iodide of potash thrice daily. Her squint, which had been due to nearly complete paralysis of her left external rectus, had disappeared; her papilloedema of 8 dioptres in each eye had disappeared. Her vision had improved from ability to count fingers at 4 metres with the right and at 60 cm. with the left eye to right eye vision $\frac{6}{12}$ and left eye vision $\frac{6}{18}$. She was herself very well. Presumably her system had been cleared of lead. To subject her to de-ionization, therefore, was putting the method to a severe test and I was prepared to be not disappointed if we obtained

a negative result. On December 4, 1918, after a 25 milliampère current had passed through her for half an hour, the negative and positive plates were handed to Mr. J. Brownlie Henderson, F.C.S., Government Analyst, for analysis, with a note regarding the possibilities. I used $7\frac{1}{2}$ to $8\frac{1}{2}$ volts and 25 milliampères of current.

Some children stand more current and the more up to 40 milliampères the better. But it is better not to frighten them and for young children 25 milliampères will do.

Mr. Henderson found just under 0.6 mgr. ($\frac{1}{100}$ gr.) of lead on the negative pole, but no lead on the positive pole. The child was, therefore, subjected to about a dozen baths of half an hour each before being discharged. When seen last, more than three months after her first visit to me, each eye saw $\frac{6}{9}$ partly and there was only slight partial post neuritic atrophy in each disc.

I next asked the House Surgeon, Dr. Lurline Dillon, whether there was a case of a marked blue line in the hospital. She told me of one, a girl aged eight years, under Dr. Selwood, with indefinite general lead symptoms and with blue lines. I found the child to have very pronounced, unusually broad blue lines in the gums, around and between quite a number of teeth.

Frankly, I was very sceptical as to the de-ionization influencing these blue lines, because our experience with ordinary treatment is that the blue lines persist for years and long after symptoms have ceased.

To my extreme satisfaction we found that the blue lines steadily diminished and that after eight baths, they had practically disappeared. Not only this, but the child rapidly improved in appearance and in condition, as well as in muscular power.

Dr. Dillon describes the child on admission as in a very collapsed state, extremely anæmic, skin lemon coloured, lips colourless. There was a history of increasing weakness for several years and of attacks of vomiting, of constipation and of epistaxis which was lately becoming more frequent and profuse. Her blood count had given only 1,850,000 red cells, some nucleated red cells and no basophilic degeneration. Her condition had improved under digitalis, magnesium sulphate, dilute sulphuric acid and iodide of potash before she was de-ionized, the red cells coming up to 3,400,000, but improvement became more marked and more rapid after de-ionization. She was admitted on November 18, 1918, and had her first de-ionizing bath December 14. She is now walking about, well covered, a good healthy colour, with the smallest possible hint of a blue line at one tooth. She has had some eight or ten baths of half an hour each.

Another colleague, Dr. Mathewson, had a patient under treatment, also with very marked blue lines. The blue lines helped much in the diagnosis, because the symptoms were atypical. Unfortunately, blue lines are not always present to help a diagnosis.

She was aged five and a half years; she was admitted in convulsions on January 9, 1919. She was not noticed to be ill until the previous day, when she had abdominal pains and vomiting. She was treated by lumbar puncture, magnesium sulphate and dilute sulphuric acid. The first lumbar puncture showed

little increased pressure. Two days later she had convulsions again, especially on the right side. She was then chloroformed and another lumbar puncture done, 14 c.cm. (3 iv.) of clear fluid being drawn off under pressure. Next day she was noticed to have a squint. There was no papilloedema. Seven days after admission she was still very drowsy; lumbar puncture yielded 28 c.cm. (3 i) of clear fluid. She was still vomiting at intervals. Some days later she suddenly became convulsed again, this time on the left side only; the convulsions continued all day. Lumbar puncture yielded 42 c.cm. (3 1½) of clear fluid under greatly increased pressure. At this time squint was much more marked and the left arm was rigid.

On January 30, 1919, I examined the discs again and found a trifle of oedema, but no measurable swelling.

On February 5 she was de-ionized for the first time. She was very weak and limp and had to be held in the baths. The bath was repeated for the next two days. Her left arm then began to regain power; her squint to become less. She could stay in the baths without assistance. After five de-ionizations she showed great improvement and was able to walk fairly well. The squint had disappeared, the twitching had ceased and she was able to move her arm. Blue lines were less marked, but were still present. After seven baths Dr. Dillon's notes say she looked very well, was much less anæmic, walked quite well, moved her left arm normally and had no squint. The blue line was disappearing and had gone altogether above several teeth. This was on March 3, 1919, less than one month after the first bath.

Oliver points out that: "as a consequence of exposure to lead there may be created immunity, i.e., tolerance on the part of an individual to it, or there may be developed anaphylaxia, i.e., an unusual susceptibility to the influence of the metal." "These conditions," he says, "are not constant. The one may pass into the other, so that a person who has been immune for years, and who has appeared to be proof against lead poisoning, suddenly becomes the subject of it."

He further points out that during life large quantities of lead may be found in the fæces of animals fed on lead, though only very minute quantities were being absorbed and perhaps no symptoms were being shown. These observations coincide with ours amongst children in Queensland.

Occasionally children, who must have been eating soluble lead off their verandah railings for months and showing no symptoms, get an attack of influenza or other illness and when convalescing, are attacked by ocular or other forms of plumbism. I used to explain this by the fact that during convalescent they kept more to verandahs and clung more round verandah rails. But an attack may come suddenly without any illness as an excuse.

It seems necessary to assume that many children are the subjects of potential lead poisoning and that the poisoning is ready to become kinetic upon some key adjustment of which we are now ignorant.

Certainly every child who bites his nails, and who inhabits verandahs with railings exhibiting powdery

lead paint, can have enough lead in his intestines to poison many children, should it suddenly become absorbed and availed of.

I am much indebted to Dr. Dillon for the interest and trouble she has taken in de-ionizing quite a lot of children. In fact, we are making an endeavour to subject past patients to the treatment in the hope of preventing future kidney, etc., trouble.

How any man expressing interest in young children can bring himself, as our master painters bring themselves, to oppose the exclusion of lead from painted surfaces within the reach of young children, passes my comprehension. Zinc white has been used on my verandah railings for the last thirteen years and has proved itself to be a better and more lasting paint than white lead. And it will not poison the children.

One senior master painter jokingly complained to me, when I first started it, that zinc white "lasted too long." Surely this cannot be the explanation. Painters are required to put on zinc paint quite as much as to put on lead paint, so it is impossible to see how they can be "put out of business" by the substitution of zinc white for white lead on surfaces within the reach of children.

Surely, also, our children are of more importance than the obligations painters may be under to the manufacturers of white lead.

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SOME RECENT ADVANCES IN OUR KNOWLEDGE OF BILHARZIASIS.

By N. Hamilton Fairley, O.B.E., M.D. (Melb.),
Major, Australian Army Medical Corps; Pathologist, No. 14
Australian General Hospital; Lecturer in Parasitology,
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(Continued from page 255.)

The Investigation of Twenty-five Experimentally Infected Monkeys.

Those animals hyperinfected with bilharziasis may die from two to five weeks from the date of infection, prior to the deposition of ova in the tissues. Death in these instances was due to toxins elaborated by the maturing worms and was accompanied by complete suppression of the cellular-humoral response (such as leucopenia, absence of eosinophilia and complement fixation reaction). The effects of these toxins on the tissues are shown by the cloudy swelling of the parenchyma of the glandular organs, such as the liver, spleen and kidney and by a round-celled periportal infiltration. In less severely infected monkeys, emaciation and general malaise may be observed as above, but they survive and localizing symptoms appear. Furthermore, in these animals the cellular-humoral response is marked. A high eosinophilia and a marked leucocytosis are present. The eosinophile myelocytes in the bone marrow are increased and a positive com-

plement-fixation⁴ is obtained in 90% of cases. It is interesting to note that localizing symptoms in the vesical form appear at least two weeks later than do dysenteric symptoms in monkeys experimentally infected with *B. mansoni*. In fact, terminal-spined ova may be found in the faeces of monkeys before they make their appearance in the urine.

Blood cultures from monkeys in the first two months are always sterile, thus disproving the suggestion of Archibald that febrile symptoms are due to secondary infection.

The Morbid Anatomy of Infected Monkeys About the Twelfth Week.

(a) *B. hæmatobia* infections.—On opening the abdomen, the liver is found enlarged and congested and studded with whitish tubercles, 0.5 mm. to 2 mm. in diameter, which are in reality minute abscesses composed of eosinophile cells. The spleen may be enlarged and congested. The colon is frequently thickened and subperitoneal and submucous nodules, 1 mm. to 3 mm. in diameter, have been noted. The omentum may form vascular adhesions to the outer surface of the colon and may tear on separation. The bladder may show massive papillomatous formations, from 5 mm. to 8 mm. in height; the mucosa is dark red and engorged. On section the uterus in the female may present the same whitish nodes or nodules in the submucous zone. The lungs are often found to be affected with a condition resembling miliary tuberculosis.

Examination of the venous system shows paired worms in quantity in the liver, portal vein, mesenteric and very especially the pelvic veins, as well as in the inferior *vena cava* and pulmonary veins.

By using a modification of Ferguson's method of digestion with 3% caustic soda, the distribution of ova in the tissues was determined to be as follows: They occur in the greatest numbers in the bladder, the uterus, liver, lung, the small and large intestines, but they also occur in the lymphatic glands, spleen and kidney.

(b) *B. mansoni* infections.—On opening the abdomen again the characteristic appearance is the large, congested liver, with similar whitish nodules. In heavily infected monkeys constant changes occur in the colon; in some cases the sub-peritoneal coat may be studded with minute nodules; in others, various grades of inflammation of the intestinal submucosa may be manifested by congestion, increased mucoid secretion, minute ulceration and scattered bilharzial tubercles. Actual papilloma formation was never observed. The lungs and bladder rarely show macroscopic evidence of the disease in this species of infection.

Ova are most commonly found in the liver, colon and small intestine and may also be demonstrated in the stomach, the duodenum, spleen, lymphatic glands, pancreas, lungs and kidney.

Microscopic Pathology of the Lesions of Both Species.

Microscopically the characteristic features consist of an infiltration of eosinophile and round mononuclear cells. Actual softening may form in the centre of these whitish nodes. (These are analogous to the eosinophile abscesses in trichiniasis.) Giant-cell sys-

tems are commonly present in the vicinity of ova and may actually form a plasmodial mass completely enveloping them. This type of cell reaction is to be regarded as a response to the mechanical irritation produced by a foreign body.

The distribution of the microscopic lesions in the body corresponds to the blood supply. For example, in the liver it is the periportal zone, in the hollow viscera the subperitoneal and submucous coats. Ova in the tissues, as well as the adult worms in the veins, exert their influence by virtue rather of a toxic secretion than of any actual mechanical action. The cytological response to bilharzia toxins is the eosinophile cell. From these lesions granulation tissue is subsequently produced and this is later replaced by fibrous tissue. The local tissue reaction and systemic response may be responsible for the death of ova, as well as of adult worms *in situ*. Not infrequently such results are noted in microscopic section.

VI.—Résumé.

As a result of these pathological and clinical studies it is obvious that bilharzia worms and probably also their ova exert their deleterious influence on the tissues mainly by toxic action.

Such a view is inevitable when one considers:—

(1) The nature of the early clinical manifestations, both in man and in experimentally infected monkeys (obviously toxic in origin).

(2) The nature of the pathological lesions demonstrable in monkeys dying two to four weeks after immersion and before ova are deposited in the tissues.

(3) The type of cellulo-humoral response. Antibody can be demonstrated in the peripheral blood of infected monkeys and man by means of a specific complement fixation test about to be described. The eosinophilia in bilharziasis and the excess of eosinophile myelocytes in the bone marrow can only result from chemiotactic or specific toxic action.

The Complement Fixation Reaction in Bilharziasis.

The frequency with which urticaria, fever and other symptoms were observed in the early stages of bilharziasis, first suggested to me the presence of some circulating toxin, the product of maturing or adult parasites.

To demonstrate the presence of immune body against such a toxin, I manufactured an antigen from the livers of snails (*Planorbis boissyi*) infected with *B. mansoni* and utilized the method of complement fixation first described by Bordet and Gengou (25). In June, 1917, I was able to report to the military authorities the discovery of a positive complement fixation test for bilharziasis.

Technique Employed.

The most satisfactory antigen is prepared by macerating a number of infected livers in a quantity of absolute alcohol and thoroughly shaking on an electric shaker. This mixture is then stored for 24 hours at 37° C. and filtered. The filtrate is evaporated at 45° C. by means of a Sprengel's exhaust-pump. The residue is dried, weighed and made up into solution with 0.85% saline solution and 0.5% phenol (0.05 grm. of residue to 20 c.c.m. solution). The anti-complementary dose is then estimated and one-third of this amount used in the test. Lately, as an alternative, I have adopted the simple procedure of

⁴ To be described in detail later on.

diluting the concentrated alcoholic extract with saline solution and not evaporating to dryness. The results so far have been most satisfactory. Besides estimating the anti-complementary dose, the antigen is always tested for hæmolytic tendency, as similar extracts of the livers of normal snails and also of those infected with allied cercariae, yield negative results. The antigen must be regarded as absolutely specific.

The general technique I now adopt is similar to that utilized for the Wassermann reaction and need not be described in detail.

Racks with four rows of tubes are utilized, the first, second and third rows containing three, five and seven minimum hæmolytic doses of complement respectively, besides antigen, saline solution and diluted serum. The back row contains three minimum hæmolytic doses of complement, but no antigen, and acts as a serum control. Antigen controls and sera ascertained to be positive and negative sera are always included in the system. The first stage of the reaction is conducted for one hour at 37° C. and then sensitized corpuscles are added, final readings being made at the end of another hour.

Results are recorded as P +, P ++, or P +++, according to the number of tubes in which hæmolysis is completely inhibited.

On an average, pooled positive sera collected from early cases of bilharziasis fix seven minimum hæmolytic doses of complement over and above that fixed by pooled negative sera in the presence of specific antigen. In more chronic cases this excess fixation amounts to about four minimum hæmolytic doses of complement.

Analysis of Results.

In 322 consecutive cases investigated by this test the following results were obtained:—

(1) In a group of 36 cases whose bilharziasis was under two years' duration, 32, or 88.8%, yielded positive reactions.

(2) In a group of 97 more chronic cases 72, or 74.2%, yielded positive reactions.

(3) In 44 cases of syphilis yielding positive Wassermann reactions, negative results were always registered. In one case a P + reaction was obtained, but here there was anti-complementary tendency shown in the serum control tube.

(4) In 150 other cases, which included protozoal, metazoal and bacterial infections, negative results were uniformly obtained. In only one case was a positive result registered where ova were not found in the dejecta, but as only one examination was made and as intestinal symptoms were present bilharzia could not be excluded. Probably the case was one of latent infection.

It is interesting to note that, as a general rule in bilharzia infections, the higher the eosinophilia, the greater the amount of complement fixed. There are, however, many exceptions, and a proportion of cases without eosinophilia yield positive reactions.

The Practical Value of This Test is Twofold.

(1) It affords a means of diagnosis, not only in latent bilharziasis, but also in very early stages of the disease prior to the onset of vesical or rectal symptoms. Thus in monkeys the reaction is generally well established by the seventh week (P +++ reactions).

(2) It affords a therapeutic index to the effect of a given drug on bilharzial worms. In this respect the test should stand in the same relationship to bilharziasis, as does the Wassermann reaction to syphilis.

VII.—Prognosis.

The experience of Smith (26) and Cottell (27), based on bilharziasis contracted in the South African war, would suggest that the prognosis regarding life in the milder grades of infection is most favourable. As the majority of our soldiers who contracted the disease in this campaign were only occasionally exposed to infection, those fell complications of the disease—malignancy and septic infections—are not so likely to ensue.

VIII.—Reflections on Treatment.

In the past it has been customary to estimate the therapeutic value of any drug in bilharziasis according to the following criteria:—

((1) The temporary disappearance of vesical or intestinal symptoms.

(2) The diminution or cessation of the passage of ova in the dejecta.

Such data, however, act as an index to the temporary amelioration of local conditions, but not to the cure of the disease.

This information tells little concerning the fate of the true causal agents concerned, *viz.*, the worms. The recent advances in our knowledge of bilharziasis, however, now affords a scientific as opposed to an empirical basis for ultimate cure.

(1) The lethal action of various drugs on worms and cercariae can be investigated *in vitro*.

(2) Monkeys can be readily infected and the effect of the intravenous injection of any drug which has been found to exert a selective lethal action *in vitro*, tested.

(3) The complement-fixation test (controlled perhaps by post-mortem examinations) can be used to determine the effect of the drug on the parasites, either in man or in experimentally infected monkeys.

In 1917 I treated four cases with repeated intravenous injections of eusol with negative results, as indicated by the facts that the complement-fixation reaction and the eosinophilia were unchanged. On *a priori* grounds this result was to be expected, as, contrary to the findings of certain observers, I find that available chlorine possesses no special lethal effects on cercariae.

Christopherson (28) has recently reported favourably on the treatment of bilharziasis with tartar emetic administered by the intravenous route.

Further confirmatory evidence of cure, as controlled by the complement-fixation reaction and the demonstration of a specific or selective action of tartar emetic in high dilutions on the adult bilharzia and cercariae *in vitro*, would be of the utmost value.

Benzene and thymol *per os* have been recommended by Robertson, but in the limited number of cases in which I have noted the effect of these drugs the results have been disappointing.

Urotropine is indicated in certain secondary infections of the genito-urinary system, but, *per se*, it naturally can have no influence on the adult parasites, since it does not liberate formaldehyde in the circulating blood.

There is no unanimity of opinion regarding the results obtained by the subcutaneous injection of emetine hydrochloride in bilharziasis.

Major P. H. Bahr, D.S.O., R.A.M.C., has very generously assisted in the compilation of the section on the history of recent literature in bilharziasis and in numerous other ways has rendered assistance in these investigations.

By his stimulating interest and advice Captain W. Campbell, R.A.M.C., has materially assisted me in the preparation for publication of this and other papers.

To both of these gentlemen my thanks are due.

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Reviews.

GENERAL PHYSIOLOGY.

The Publication Department of the Rockefeller Institute for Medical Research has established the *Journal of General Physiology*, to be devoted to the explanation of the phenomena of living things on the basis of the physical characters and chemical constitution of the components of living substance. At present two other periodicals, the *Journal of Experimental Medicine* and the *Journal of Biological Chemistry* are published under the auspices of the Rockefeller Institute. We welcome this venture and wish it success. It is gratifying to note that an Institute for Medical Research is the first body to publish in the English language a periodical dealing with the subjects of general and cellular physiology. While it has been widely accepted that these studies of the properties of life which are applicable to the majority of living objects are more fundamental in character, little investigation has been carried out in British laboratories on these aspects of biology. American laboratories have given more attention to these matters.

The first number¹ of Volume I. contains eleven papers and comprises 130 pages. Professor J. Loeb, of the Rockefeller Institute, one of the Editors, contributes two articles. The first discusses amphoteric colloids and considers the influence of hydrogen ion concentration. The second is a contribution to the study of regeneration in the stem of *Bryophyllum calycinum*. The other Editor, Professor W. J. V. Osterhout, of Harvard, also writes two articles. The first is a record of an experimental study of the dynamics of photosynthesis and the second is a description of an apparatus for studying respiration, which can be used with many small animal forms. E. Uhlenhuth deals with the production of tetany in salamanders by feeding them on thymus glands and with the antagonism between the actions of the constituents of the thyroid and parathyroid glands. S. C. Brooks set forth a theory of the general mechanism of disinfection, hemolysis and similar processes leading to the death and dissolution of living cells. In general, this author protests against the assuming that death in the case of bacteria or laking in the case of erythrocytes occurs suddenly. He asserts that these states are brought about slowly by processes progressing with constant velocities. He considers that erroneous views result from the popular conception that bacteria die instantaneously. He cites the slow onset of cellular death in a large animal.

The *Journal* will be issued bi-monthly and one volume will appear each year.

Naval and Military.

HONOURS.

The following notices have appeared in the *London Gazette* during the month of January, 1919:—

Distinguished Service Order.

Major Donald Dunbar Coutts, Australian Army Medical Corps, attached 24th Battalion, Australian Imperial Force. For conspicuous gallantry and devotion to duty.

¹ The *Journal of General Physiology*, Edited by J. Loeb and W. J. V. Osterhout. Baltimore: The Rockefeller Institute for Medical Research; September, 1918; Volume I., Number 1. Subscription, 21s. per volume.

On September 1, 1918, during the attack at Mont St. Quentin, although the regimental aid post was consistently shelled, he attended the wounded almost continuously for fifty-two hours, during five of which he was forced to wear his gas respirator, displaying throughout the greatest courage and devotion to duty. On the day prior to the attack a shell burst on a dug-out, wounding several men and pressing one down, severely wounded, blocking the entrance. He immediately went forward, regardless of intense shell fire, and succeeded in extricating the man and removing him, over exposed ground, to the rear.

Bar to Military Cross.

Captain Kenneth Arthur McLean, M.C., Australian Army Medical Corps, attached 7th Brigade, Australian Field Artillery. For conspicuous gallantry and devotion to duty. On August 31, 1918, near Clerf, the battery was heavily shelled, two men being killed and two badly injured. He immediately went to the battery and commenced dressing one man who could not be moved. He continued his work until one shell burst close to him, wounding him severely in the arm and mortally wounding the stretcher-bearer who was assisting him. He showed marked courage and devotion to duty. (M.C. gazetted July 26, 1918.)

Captain Cedric Murray Samson, M.C., 9th Field Ambulance, Australian Army Medical Corps. For conspicuous gallantry and devotion to duty. On the morning of August 22, 1918, north of Chipilly, on the Bray-Corbie Road, he took a car along to the regimental aid post in spite of heavy shelling and gas. He superintended the line of evacuation, continually taking fresh squads up to the regimental aid post through heavy fire. Again, on August 31, he dressed a wounded medical officer and his orderly in the open, being wounded while doing so. During the period August 20 to 31, 1918, his fearless energy and devotion to duty were responsible for the rapid evacuation of so many wounded. (M.C. gazetted June 3, 1918.)

We have been informed that Lieutenant-Colonel Clement Lorne Chapman, D.S.O., Australian Army Medical Corps, who has served on the staff of the 1st Anzac Corps, has been awarded the *Médaille des Epidémies (en argent)* for services rendered to the civil population during the retreat of 1918. Major Alan Worsley Holmes a'Court has also received this distinction.

APPOINTMENTS.

The following appointments, etc., have been announced in the *Commonwealth of Australia Gazette*, No. 38, of March 27, 1919:—

Australian Imperial Force.

Army Medical Corps.

To be Captains—

Eric Francis Erby. Dated 10th March, 1919.

Noel Benson Charlton. Dated 10th March, 1919.

APPOINTMENTS TERMINATED.

Second Military District.

Major J. R. N. Beith. Dated 28th April, 1919.

Australian Military Forces.

Australian Army Medical Corps—

Honorary Majors J. H. Downing and H. Grover, being granted pay at the rate of £600 per annum whilst employed as Staff Officer to Director-General, Australian Army Medical Services, and Adjutant to Principal Medical Officer, 3rd Military District, respectively, to date from 16th October, 1918.

Second Military District.

The undermentioned, who have served in the Australian Imperial Force as Commissioned Officers, having the rank held by them in the Australian Imperial Force confirmed as honorary rank in the Australian Military Forces, as follows:—

Officers who, on appointment for active service

outside Australia, were serving, and are now serving in the Australian Military Forces:—

Captain W. E. Kay, D.S.O., Australian Army

Medical Corps. Dated 19th September, 1917.

Captain J. Relach, Australian Army Medical Corps. Dated 20th July, 1918.

The undermentioned, who have served in the Australian Imperial Force as commissioned officers, being appointed to the Australian Army Medical Corps Reserve (temporarily), and being granted honorary rank equivalent to that held by them in the Australian Imperial Force:—

Officers who, on appointment for active service outside Australia, were not serving in the Australian Military Forces:—

To be Honorary Majors—

W. M. A. Fletcher. Dated 14th November, 1916.

A. S. D. Barton, D.S.O. Dated 14th November, 1916.

C. J. Tozer, D.S.O. Dated 20th June, 1917.

W. Evans, M.C. Dated 20th June, 1917.

To be Honorary Captain—

E. E. Pittman. Dated 23rd April, 1917.

PAY AND ALLOWANCES OF MEDICAL OFFICERS IN THE ROYAL AUSTRALIAN NAVY.

The Naval Board has recently revised the regulations governing the rate of pay of medical officers serving in the Royal Australian Navy. The former rates will be found in *The Medical Journal of Australia*, August 31, 1918 (pp. 190-191). The new rates will come into force on April 1, 1919. They are as follows:—

	Active Pay. Per diem. s. d.	Deferred Pay. Per diem. s. d.
Surgeon-Lieutenant—		
On entry.. .. .	24 0 ..	5 0
Two years	24 6 ..	5 0
Four years	25 0 ..	5 9
Six years	26 0 ..	5 9
Surgeon-Lieutenant-Commander ..	29 0 ..	6 6
Two years	30 0 ..	6 6
Four years	32 0 ..	7 0
Six years	33 0 ..	7 0
Surgeon-Commander	37 0 ..	8 0
Two years	38 0 ..	8 0
Four years	40 0 ..	9 6
Six years	42 0 ..	10 0
Eight years	44 0 ..	10 0
Ten years	45 0 ..	10 0

Compound interest will be paid on deferred pay, to be credited annually on June 30 of each year on balance at the end of the previous year.

Married Allowance (if married).—Payable to Surgeon-Lieutenants and Surgeon-Lieutenant-Commanders:—

Number of Children	Rate per diem. s. d.
Under 16 years.	
None	2 6
One	3 0
Two	3 6
Three	4 0

Ration Allowance.—Payable at the rate of 2s. 6d. per diem whilst on leave or detached duty.

Outfit and Uniform.—£60 gratuity on entry (£30 to temporary Surgeons) and 1s. per diem upkeep allowance.

The chief task that a coroner is called upon to carry out is to determine the cause of death in cases when a medical practitioner has not had the opportunity of investigating the illness, or when a suspicion of foul play exists. It is therefore obvious that medical knowledge is an essential in the equipment of a coroner. We regret to note that the successor of Dr. S. Macky, until recently the coroner for Lockhart and a coroner for the State of New South Wales generally, is a layman.

It is with great regret that we have to record the death from influenza of Dr. John Kennedy Freyer, of Orange, Dr. Noel Halford Franki, of Randwick, and Dr. James Percy Clifford, also of Randwick.

The Medical Journal of Australia.

SATURDAY, APRIL 5, 1919.

The Medical Officers' Relief Fund.

In August last the Federal Committee invited the New South Wales Branch of the British Medical Association to nominate three of its members to act as Trustees to the Medical Officers' Relief Fund. In the latter months of the year the Council of the New South Wales Branch nominated Dr. W. H. Crago, Dr. George Armstrong, and Dr. R. Gordon Craig, and in January of this year the Chairman of the Federal Committee, Dr. W. T. Hayward, acting on the powers vested in him by the Committee, appointed these gentlemen as Trustees. In another column of this issue we publish a short announcement that two of the Trustees made to the New South Wales Branch on March 28, 1919. Dr. Crago referred with regret to the delay that has been occasioned in the starting of the fund. In March, 1917, Dr. F. S. Hone made the proposal that a fund should be started for the benefit of those who returned from active service handicapped in some way. From time to time we have dealt with this subject in these columns, and the suggestion gradually took shape, until it gained acceptance in all parts of the Commonwealth. It was hoped that a relatively short time would reveal to some extent the approximate number of returned men who would need assistance and the number of dependants of those who had given their lives in the service of their country. Without an indication of this kind it was sheer guesswork to estimate the amount of money that might be required for a Federal medical war fund. Unfortunately time has not disclosed the extent of our obligations to our brave colleagues. The Trustees have made a tentative suggestion that £50,000 will be required. They have, no doubt, endeavoured to form the estimate on the information available at the present time, and have hesitated to ask for too large a sum, lest the actual largeness deter men from embarking on the scheme with confidence. We are prepared to accept this estimate as a working

basis, and recognize that with £50,000 in hand the Trustees could do much towards carrying out the aims of the Federal Committee and of those who have advocated this fund. We have no fear concerning the result. Australian medical practitioners will never fail in performing an important duty, no matter what difficulties have to be faced and overcome. We venture to go one step further. We appeal to the medical practitioners of the Commonwealth to strain every nerve until the Trustees have in safe custody double the amount that is being asked for. It is not so immense a sum when there are more than 2,000 potential subscribers. There are men who can give £100 without difficulty. We have heard it whispered that some of the more fortunate leaders of the medical profession may write cheques of four figures. The less prosperous will want to contribute smaller amounts in proportion to their means. It is to be anticipated that the majority will not be in a position to give more than £50, either in one payment or in two or three instalments. Our message to those who have not been fortunate enough to have taken part in the "great game" is brief and direct:—The local committees will soon ask for your donations; give as much as you can; it is your duty; it is your privilege.

THE FINAL STAGES.

The signing of the armistice, the termination of hostilities and the anticipation of the conclusion of peace have given the people of Australia a feeling of a task completed. It is true that the more thoughtful citizens have long recognized that the work of demobilisation would take a considerable time and might be attended by unforeseen difficulties, and that the repatriation of our soldier lads was fraught with dangers and pitfalls. While the war lasted the Director-General of Medical Services experienced much difficulty in supplying the Australian Imperial Force and the other expeditionary forces with a sufficient number of medical officers. The remembrance is still fresh of the opposition raised to the enlistment of medical students as combatants. This expedient was adopted to ensure a constant supply of medical officers for the army. Many of the men who are now graduating, were prevented from enlisting for this purpose, while others who could have done so, re-

frained for the same reason. The Director-General looks to these young graduates to place their services at his disposal now, for the purpose of assisting in the final stages. There are returned soldiers in increasing numbers to be treated. The medical students of yesterday, who could not accompany these men on active service, are graduates to-day, and it is their moral duty to undertake service at home. The Department will otherwise be compelled to call upon the medical officers who have served overseas, to continue their war duties on their return to Australia. The task of looking after the incapacitated soldiers is earnest and important work. It is true that there is no excitement, no adventure associated with this work, but it is of national importance. We need not dwell on the reasons why the junior staffs of the military hospitals should be made up of the youngest graduates of our universities. When it is realized that each man joining releases a medical officer who has made a large sacrifice overseas, they will, we feel convinced, offer their services until the requirements of the military authorities have been met. We therefore appeal to the younger members of the medical profession to enlist in the Australian Army Medical Corps for home service without loss of time.

THE SEARCH FOR TRUTH.

Our attention has been directed to a difficulty experienced by many of the readers of *The Medical Journal of Australia* in understanding some of the editorial discussions dealing with the more technical aspects of disease processes. This difficulty has arisen in connexion with every medical journal intended for general practitioners of medicine. During the past few decades criticism has been levelled at every one of these journals because they have contained too little science and because the records of progress in the laboratory have been of too elementary a nature. The reply to this criticism has been the introduction of technical discussions. This has resulted in a loud complaint that the general practitioner, having no opportunity to participate in laboratory research, is not directly concerned with this specialty. It has been suggested that the proper place for discussions of this kind would be those periodicals that are devoted to the subjects of medical research, bacteriology, pathology and immunology. Those responsible for the conduct of the general practitioners' journals were thus placed on the horns of a dilemma. It almost seemed as if there were no escape from the apparently justified double criticism. In the majority of cases an attempt was made to compromise, but a tendency usually became evident to lighten the task of the reader by the avoidance of the more intricate and

complicated problems. There is, however, a very potent reason for opposing this attitude and for aiming at a compromise leaning rather toward the inclusion of the more technical aspects of medicine. Every medical practitioner is called upon to treat patients suffering from divers diseases, and the patient expects when the condition for which he seeks relief is not thoroughly understood, that the general practitioner will seek the aid of a specialist colleague. Specialism has hitherto been reserved to the special systems and organs of the body. The general practitioner still holds his own as the practical authority on the infective processes which affect man, perhaps with the one exception of tuberculosis. We hope that this will be maintained. It seems therefore that the general practitioner is or should be greatly concerned in the knowledge accumulated by the research worker, which may help to unravel some of the tangled skeins connected with the causation of symptoms, of the onset and termination of infective processes and of the protective arrangements which usually suffice to keep disease away from human beings. The sum of the knowledge possessed at present concerning these difficult questions is small, but each established fact must be treasured until the chain of evidence is complete. It is useless to record clinical histories of cases or the results of new modes of treatment of disease unless the reader has an opportunity of ascertaining what has been done to investigate the pathological process itself. The endeavour has been made in this journal to record the more important facts elicited in research and to discuss the significance of the findings, as far as this is practicable and advisable. At the risk of incurring the charge of being dogmatic, this journal has sought to convey information of a useful character to its readers. The opinions and views of those who have had extended experience of the particular subject or group of subjects dealt with is always sought. Care is taken to weigh the evidence adduced in support of any new theory or explanation of an observed phenomenon, while the available contemporaneous literature bearing on the matter is studied. The sole object is to arrive at the truth, and when our knowledge is insufficient to justify a conclusion being drawn, we have admitted our ignorance. This journal would be of greater value to the members of the medical profession in Australia if they would indicate to the Editor when these discussions become difficult to follow. It would be possible to publish articles giving a more detailed explanation of the phenomena and theories that are usually referred to in brief terms, if our readers would ask for specific information. To ignore the march of science would be to surrender all claim on the part of *The Medical Journal of Australia* for recognition among the scientific publications of the world.

THE CYANOSIS OF INFLUENZA.

In the discussion on the epidemic of influenza at a recent meeting of the Victorian Branch of the British Medical Association, Dr. W. S. Newton referred to the symptom of cyanosis which has attracted

considerable attention in all parts of the world.¹ He found that it was common in severe cases and, when marked, was associated with fatal illness. He determined that it was not due to failure of the right side of the heart, and he noted that the inhalation of oxygen did not influence it. Dr. R. R. Stawell² expressed the opinion that even the late and severe cyanosis was not due entirely to pulmonary involvement. He suggested that it might be caused by the appearance of methæmoglobin in the blood, although he had not demonstrated the spectroscopic characteristics. Dr. J. G. Whitaker attached much importance to a distinction between the early cyanosis and the late cyanosis. He dealt with this symptom from the prognostic point of view, and did not attempt to analyse its significance by tracing it to its causation. Previous writers had arrived at similar conclusions. The facts hitherto determined have been entirely negative. The cyanosis is not caused by embarrassment of the pulmonary circulation. We learn that this symptom has been studied with considerable care by the medical officers of the Johns Hopkins Hospital during an epidemic affecting the nursing staff, students and others living in the Hospital. Dr. G. A. Harrop, junior,³ has investigated the oxygen content of the venous blood in the several stages of the disease, and has measured simultaneously the oxygen-combining power. Lundsgaard has suggested that the significance of the blood changes in cyanosis can best be estimated by registering the difference between the oxygen-combining power of the hæmoglobin and the oxygen content of the blood. He calls this measurement the oxygen unsaturation. In ordinary lobar pneumonia it has been determined that the decrease of respiratory surface in uncomplicated cases is compensated and consequently there is no diminution of the oxygen content of the venous blood. When pulmonary œdema supervenes and the right side of the heart is impaired, a gradual decrease in the oxygen content occurs. Simultaneously there is a fall in the oxygen-combining power of the hæmoglobin. This is usually not as great as the fall in the oxygen content. The diminution in the oxygen-combining power of the hæmoglobin is probably due to the formation of methæmoglobin and the consequent interference with the capacity of the pigment to take up oxygen.

Dr. Harrop found that the oxygen content and the oxygen unsaturation remained within the limits of normal values in uncomplicated cases of influenza, even when the cyanosis was distinct. In the cases complicated by broncho-pneumonia the same results were obtained until the terminal collapse. In the final stages of these cases the oxygen-combining capacity and the oxygen content decreased progressively and equally. These findings therefore demonstrate that the cyanosis is not caused by any disturbance of the hæmoglobin or of the pulmonary circulation until the terminal collapse occurs, when pulmonary œdema is present. Both he and Dr. Arthur Bloomfield maintain that the so-called cyanosis is in reality an erythema. In well-marked cases it is an intense dusky, reddish-plum-coloured erythema in-

volving the face, lips and the upper part of the chest. Occasionally it extends over the whole of the chest and back, and it may involve the skin of the arms and legs. They state that the suffused appearance is similar to that seen in *polycythæmia vera*. They hold strongly to the opinion that it differs from a true cyanosis. The colour disappears on pressure and returns instantly the pressure is removed. This observation, if confirmed, is important, since it would indicate that the blueness noted in cases of influenza (not the cyanosis associated with increasing pulmonary œdema) is a specific skin reaction to the primary causative organism of the disease, whatever that may be.

We learn from the *British Medical Journal* of February 8, 1919, that a special scientific and clinical meeting of the British Medical Association will be held in London during the week from April 8 to April 14, 1919. The organizing secretary of the section of medicine is Colonel C. T. C. de Crespigny, D.S.O., Australian Army Medical Corps, while the secretary of the section for surgery is Colonel C. H. S. Frankau, D.S.O., Army Medical Staff. Major Ellis, of the Canadian Army Medical Corps, has been invited to take charge of the section of preventive medicine and pathology. Pending his acceptance of the position, Professor S. G. Shattock, F.R.S., and Dr. J. A. Arkwright, of the Lister Institute of Preventive Medicine, have consented to act as secretaries. They have had the advantage of the assistance of Lieutenant-Colonel C. J. Martin, F.R.S.

Members of the British Medical Association in Australia will be pleased and surprised to learn from the Sons of Australia of the wide powers which they possess. At a meeting of the Grand Council of this institution a resolution was carried to the effect that the Branches of the British Medical Association in Australia should be abolished or disbanded, on the ground that "their continuance as an authoritative body is inimical to the interests of Australian-born medical students, citizenship and advance Australia." The suggestion was made that, in lieu of the Australian Branches of the British Medical Association, an Australian Medical Board should be set up, composed exclusively of Australian-born medical practitioners. All medical practitioners should practice subject to the licence of the Australian Medical Board. The Sons of Australia have not divulged the means they propose to adopt to carry these suggestions into effect.

A proposal has been made by the Committee of Management of the Melbourne Hospital to the Department of Defence that if the Department would undertake to defray the expenses incurred, the Committee would be prepared to find room for six returned medical officers on the resident medical staff by increasing the staff from twelve to sixteen. The tenure of office would be for six months. The Department has suggested that this matter belonged rather to the functions of the Repatriation Department. The proposal is an excellent one, and we hope that it will not be allowed to be put aside on account of the difficulty of persuading a Government Department to recognize its duty.

We learn from the public press that Major Henry Hunter Griffiths, Medical Officer of the No. 3 Sea Transport Staff, Australian Imperial Force, died of pneumonia following influenza on March 23, 1919. Major Griffiths was employed for a couple of years in the Military Hospitals for Venereal Diseases in Australia and was gazetted for service with the Australian Imperial Force on February 26, 1916. He obtained his majority in November, 1917, and was transferred to the Sea Transport Staff before the end of that year.

¹ *The Medical Journal of Australia*, March 15, 1919, page 212.

² *Ibid.*, page 226.

³ *Bulletin of the Johns Hopkins Hospital*, January, 1919.

Abstracts from Current Medical Literature.

SURGERY.

(118) Operative Procedure of Nerve Injuries.

The operative procedure in nerve injuries is discussed by Robert Kennedy (*Brit. Journ. Surgery*, October, 1918). Any initial wound or sinus should first be allowed to heal and then the cutaneous scar dissected out. The separated ends having been found, conductivity is tested with an interrupted current, a sterilizable electrode being used. All scar tissue surrounding the nerve is excised and care taken to avoid the nerve being confined to a narrow space. Therefore, in lesions of the ulnar nerve behind the condyle it must always be displaced forwards so as to lie in front. Posture will help coaptation, e.g., in sciatic nerve lesions, by flexion. Stretching of the nerve trunks is also of value where there is shortening. This may be done by grasping the nerve trunk with gauze or by using a special nerve stretcher, such as the one Kennedy has devised. Displacement forward of the ulnar nerve gives an increased length. It may be done by passing the distal end of the nerve through an opening in the muscles, or by incising and later re-suturing the ulnar head of the *flexor carpi ulnaris*. If coaptation is still impossible and the lesion involves only one of two neighbouring nerves, such as the ulnar and median, the sound nerve may be incised transversely for one-third of its thickness at two points widely separated. Into these gaps the distal and proximal ends of the injured nerve are inserted. For suturing Kennedy uses a special curved needle, flattened from side to side, with a cutting edge both on the concavity and on the convexity, the eye being in the same plane as the cutting edge. The nerve is transfixed by a single suture which passes through the whole substance of the nerve. Fine, specially-prepared chromic catgut is recommended.

(119) Dilatation of Common Carotid Artery Distal to a Partial Occlusion.

A case of aneurysm of the right subclavian artery is related by Halsted (*Surg., Gynec. and Obstet.*, December, 1918), in which a band was placed on the innominate artery and the subclavian itself ligated in its first and third parts. Twelve years later there was no sign of the aneurysm, but there was a marked cylindrical dilatation of the common carotid artery, its greatest breadth being 2.8 cm. This confirms the results of the experimental work previously carried out by Halsted and Reid on the cylindrical dilatation of the distal portion of an artery following partial occlusion. Halsted points out that in an analysis of 525 cases of cervical rib 106 were found in which the subclavian artery was compressed, and of these 27 showed aneurysm or dilatation of the vessel distal to the constriction. Further, clinical and experimental study of

arterio-venous fistulae shows that invariably there is secondary hypertrophy of the heart. He holds that the abnormal whirl-pool-like play of the blood in the relatively dead pocket below a partially constricted vessel, together with the lowered blood pressure, is the chief factor causing the dilatation.

(120) Salivary Fistulae.

H. Moreston (*Bull. et Mem. de la Soc. de Chir.*, October 30, 1918) explains his method of dealing with salivary fistulae. In 1917 he published a record of sixty cases. He now gives an additional twenty-four cases all due to war wounds and all rapidly cured. For glandular fistulae, e.g., in the parotid, he extirpates *en bloc* the cutaneous scar and the fibrous tissue surrounding the track right down into the parotid substance. The space left is carefully approximated by deep sutures and the entire wound closed. Where the duct is involved, the same procedure is followed, but in addition the proximal end of the duct is ligatured and buried. In a certain number of cases salivary cysts have followed, but after repeated punctures the encysted fluid has progressively diminished and ultimately disappeared. He considers this method preferable to that of short-circuiting the duct into the mouth, since the cut end of a duct inevitably becomes impermeable.

(121) Gonorrhœal Empyema.

A case of gonorrhœal empyema is recorded by H. S. Woodbery (*Surg., Gynec. and Obstet.*, December, 1918). Only sixteen cases of this condition have previously been published. In spite of the tendency of the gonococcus to affect serous membranes, the pleura is not often affected. The patient, a child, *et 8*, was admitted to hospital with an acute abdominal condition, thought to be appendicial in origin. A peritonitic lesion was discovered and the abdomen drained. Six days later there were signs of fluid at the right base and aspiration yielded thick yellow pus. A thoracotomy was performed, but the child died twelve hours later. Meantime, it had been discovered that she had a profuse vaginal discharge and smears from this and from the pus of the empyema demonstrated numerous gonococci. A blood culture made before death was negative.

(122) Gunshot Wounds of the Lower Jaw.

The principles of the treatment of gunshot wounds of the lower lip and mandible are set forth by Kazanlian and Burrows (*Brit. Journ. Surgery*, July, 1918). The early treatment is directed towards saving life. The dangers are broncho-pneumonia and respiratory obstruction from oedema of the glottis or the falling-back of a loosened tongue. The patient is fed nasally and the wound cleaned up. To restore the mandibular function the remnants of the lower jaw must be kept in position and temporary splints used as soon as possible. An artificial jaw of vulcanite is made and held in position by any remaining teeth or by the alveolar ridges

of the jaw, and also by occlusion. It has sufficient bulk to replace the missing bony tissue and to give prominence to the symphysis. The lower lip is then restored by flaps from the cheeks and the sides of the neck.

(123) Results of Primary Excision of the Elbow Joint.

Eleven consecutive cases of primary excision of the elbow joint following gun-shot wounds are analysed by Eisdell Moore (*Brit. Journ. Surgery*, October, 1918). He calls attention to the important relationship between the amount of bone removed and the functional result; the more bone taken, the more useless the arm. Ten of these patients had more or less flail joints. The argument for wide removal is that sepsis is more efficiently controlled. The preservation of the muscular attachments of the triceps and *supinator longus* is an important point. In post-operative treatment the forearm should be supported to prevent stretching of the fibrous union, and rest is more important than early movement. The flail joint may be treated by a support, by massage and electricity, or by capsulorraphy.

(124) Jejunal Alimentation for Duodenal Fistula.

Einhorn (*Med. Record*, November 30, 1918) records a case in which jejunal alimentation was employed for a duodenal fistula following a cholecystectomy by Willy Meyer. The patient's condition had become grave from inanition when Einhorn introduced a duodenal tube into the jejunum (95 cm. from the lips) and fed the patient with lactose and milk by the drip method. Three weeks later this tube was replaced by another, and after seven weeks of jejunal feeding the duodenal fistula had closed. He points out the grave prognosis from duodenal fistulae, recovery being rare. Inanition and dehydration rapidly lower the patient's vitality, while the digestive action of the secretions causes a progressive enlargement of the wound. Alarming bleeding may occur from the raw surfaces, and fat necrosis has been observed.

GYNÆCOLOGY AND OBSTETRICS.

(125) Ectopic Pregnancy.

During the course of 27 years 302 patients with ectopic pregnancy have been under treatment in the Gynecological Service of the Johns Hopkins Hospital. H. M. N. Wynne (*Bull. Johns Hopkins Hosp.*, January, 1919) publishes a full summary of the data recorded in connexion with these patients. The incidence of extra-uterine pregnancy has been 1.3%. The youngest patient was 15 years of age and the oldest 45 years of age. Seven of the 303 patients were under 20 and 10 were over 40, while 182 were between 24 and 33 years. In 21% there had been no previous pregnancy and, of the remainder, 5% had had only miscarriages. The symptoms which caused the patients to seek relief were pain in 254 cases or 84%, bleeding in 93 or 31% and

tumour in 22 or 7%. Abdominal pain was present in 300 patients. The remaining three patients stated positively that there was no abdominal pain or discomfort. In these cases an unruptured tubal pregnancy was found at the operation. The onset was acute without prodromal symptoms other than bleeding or a missed period in 48%. It was acute with prodromal symptoms in 24% and it was gradual without acute symptoms in 28%. Other symptoms, such as nausea and vomiting, fainting, fever, weakness, urinary frequency and the like, were present in varying numbers of patients. Recurring attacks of pain were met with in 102 cases. In some instances the pain was associated with old standing inflammatory trouble and exacerbations were complained of. The pain rarely seemed to radiate. It was described as violent in 90 cases, cramp-like in 41, bearing down in 14, dull or aching in 29, cutting in six, like labour pains in nine and colicky in four. One hundred and three patients stated that they had missed one or more periods; 31 patients stated that the last period had been overdue from one to five weeks. In 17% there had been some abnormality of the last period. Wynne does not attach much importance to the condition of the cervix in these cases. Unless the foetus is living, gross changes are not usually found. The physical signs included abdominal distention (30%), tenderness in 60%, signs of free fluid in the abdomen 10%, tumour 24%, sanious discharges 25%, softening of the cervix 25%, enlargement of the cervix 16%, enlargement of the fundus 25%, vaginal cyanosis 2%, a tumour mass 49%, lactating breasts 2% and colostrum 50%. The majority of the patients were febrile and had an increased pulse-rate. The pre-operative diagnosis was recorded in 212 cases. In 98 cases or 46% it was correct; in 12 further cases the correct diagnosis was arrived at after the patient was under an anaesthetic and in five a probable diagnosis of extra-uterine pregnancy was made. In 28 instances the condition was suspected but not definitely diagnosed before operation. In the remaining 69 cases the extra-uterine pregnancy was not diagnosed, although a co-existing pathological condition was recognized in several instances. It is pointed out that the presence of another condition may render a positive diagnosis of the ectopic gestation impossible. Wynne admits that an erroneous diagnosis of extra-uterine pregnancy was not uncommon. The treatment was by operation either by the abdominal or by the vaginal route. A vaginal operation was conducted in 8% of all cases and included pelvic puncture, dilatation and curettage, salpingectomy, etc. In 92% laparotomy was performed. Unilateral salpingectomy, unilateral oophorectomy, bi-lateral salpingectomy, hysterectomy, bi-lateral oophorectomy, total extirpation of the sac and its contents and resection of one ovary were the most frequent procedures employed. When the peritoneal cavity is opened blood and clot are carefully re-

moved. In eight cases, however, no attempt was made to evacuate the blood. It is stated that convalescence is more satisfactory when this is carried out. Formerly, irrigation of the peritoneal cavity was used, but in recent years the practice has been discontinued. Primary drainage was employed in 150 cases, the gauze cigarette drain being used. Sub-cutaneous injections of salt solution, rectal injections of salt solution with or without coffee, an injection into the peritoneal cavity of salt solution form the chief stimulants employed. Strychnine, digitalis, brandy and ether were used on few occasions. The mortality was 4.3%, while in 89.4% the patients regained complete health. Enquiry elicited the subsequent history of 127 patients. In 33 of these patients a further pregnancy had been rendered impossible. Among the remaining 96, 36 had become pregnant one or more times. The total number of pregnancies was 61 and, of these, 37 resulted in full-time children. In five patients a second ectopic pregnancy occurred.

(126) High Carbo-Hydrate Feeding in Hyperemesis.

Duncan and Harding (*Canadian Med. Assoc. Journ.*, December, 1918) have approached the general subject of the toxæmias of pregnancy from a new aspect by investigating the very mild and almost innocuous types of early nausea and vomiting instead of the more aggravated and serious forms. They propose giving the results of their study of the later toxæmias in a subsequent paper. In regard to the three types of the disease (1) reflex, (2) neurotic and (3) toxæmic, the authors consider that the reflex form is very rare. They are inclined to incorporate the second or neurotic type with the toxæmic and to look upon the neurosis as an exhibition of a disturbance of the nervous system by the toxæmia. In a general outline of treatment they make the following points: morning sickness in the milder forms occurs only when the stomach is empty, indicating that a period of hunger is necessary to produce vomiting. This period of hunger tends to produce a relative lack of glycogen in the liver, and this leads to fatty infiltration of that organ, with an associated acetonaemia. They have found that lactose as a source of glycogen for immediate treatment is more satisfactory than glucose or cane sugar. This is administered by the mouth or *per rectum* according to the severity of the symptoms. Emphasis is laid on the fact that as soon as possible the patient is placed on a high carbo-hydrate diet, fresh fruit and vegetables forming the larger portion. Fats and proteins are eliminated as much as possible. They have treated 70 cases, 42 mild, 17 moderately severe and 11 severe or pernicious. All of the patients recovered and continued on to term. In the mild class of case (vomiting up to twice daily) the patient is advised to rest and the demands of housekeeping are limited. Meat and fatty foods are

eliminated and their place is taken by a liberal supply of carbo-hydrate food, such as potatoes, rice, oatmeal, vegetables and fruit. In addition one to one and a half litres of a 5% lactose solution are taken daily by the mouth. When the nausea and vomiting are fully controlled the lactose is rapidly cut down to 15 grammes per day and the patient quickly returns to ordinary diet. Recovery followed rapidly in 42 patients treated in this way. In the moderate type (vomiting more than twice daily, but not continuous, with distinct signs of toxæmia) rest in bed with correction of any excretory defects is insisted upon. The diet is as above and one to one and a half litres of a 5% to 10% lactose solution are given daily by the mouth if it can be tolerated, if not, it is injected slowly into the rectum, 285 c.cm. being given every four hours. If lactosuria appears the lactose is diminished in amount. As soon as possible carbo-hydrates are pushed. Proteins can be administered as soon as the nausea is under control, but fats are withheld for some time. Severe or pernicious type (vomiting continuous and marked symptoms of toxæmia) rest in bed with complete isolation is insisted on. No attempt is made to force food at first. Bowel action is procured by enema. The lactose solution is administered *per rectum*, as in the moderate type. If it is not retained 200 c.cm. of a sterilized 5% glucose solution is injected under each breast. One injection has always proved sufficient. The rectal administration of lactose is changed to oral as soon as possible. As soon as the patient shows any inclination for food, small amounts of carbo-hydrates are given at frequent intervals. The continuation of the treatment and the dieting then follow the course prescribed for the moderate and mild cases. The results in all cases were good; relapses were usually traceable to indiscretion in diet. In two cases nausea with hyperacidity persisted to term. Among the pernicious type were three women who had had abortion induced for vomiting in previous pregnancies.

(127) Double Ectopic Gestation.

Edward Sharpe (*South African Med. Rec.*, January, 1919) describes the conditions found post-mortem in a case of double ectopic gestation. The history was that the patient expected to be confined in December, 1917, but after spurious labour the signs of pregnancy disappeared. Menstruation returned and continued till October, 1918. The patient died suddenly in December, 1918. The post-mortem examination revealed the following condition. The abdominal cavity was filled with clotted blood which had come from a ruptured ectopic pregnancy of the left tube. On the right side there was a mass about the size of a football attached by fibrous bands to the intestine and the right tube. This mass contained a large foetus and placenta, but no liquor amni. The foetus had not decomposed, but was pressed out of shape.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the New South Wales Branch of the British Medical Association was held at the B.M.A. Building, 30-34 Elizabeth Street, on March 28, 1919, Dr. A. A. Palmer, the President, in the chair.

Annual Report.

The Annual Report of the Council for the year ending March 28, 1919, was presented by the Honorary Secretary, and was received. The report is as follows:—

Annual Report of the Council.

The Council has the honour to present the following Report upon the work of the Branch for the year ended March 28, 1919:—

Membership.—The number of members is now 1,136 as against 1,091 at the date of the last Annual Report. The losses have been as follows, namely: by resignation, 4; by removal out of the area of the Branch, 14; by non-payment of subscription, 9 (not including a number of members absent on military service, on whose account payment has been made vicariously to the London Office to prevent the lapse of their membership, which otherwise would have occurred automatically under the Articles of Association of the parent Association); by death, 15. The losses by death were as follows: Dr. R. Dey, Dr. T. W. Francis, Dr. R. Ferguson, Sir Phillip Sydney Jones, Dr. E. H. Bottrell, Dr. S. L. Richardson, Dr. J. McLeod, Dr. H. G. S. Warren, Dr. T. W. Faulkner, Dr. G. B. Thomas, Dr. J. K. Freyer, Dr. J. B. Metcalfe, Dr. R. A. Sillar, Dr. J. S. Wilson and Dr. H. E. Kirkland. Of these, four died while absent on active military service, namely: Dr. J. B. Metcalfe (died of wounds, April 25, 1918), Dr. R. A. Sillar (died on service, June 30, 1918), Dr. J. S. Wilson (died of wounds, August 19, 1918), Dr. H. E. Kirkland (killed in action, October 30, 1918).

Meetings.—Eleven ordinary meeting, including the Annual Meeting, and two extraordinary meetings of the Branch were held, with an average attendance of 41. There were eight clinical evenings, with an average attendance of 34. The business of the ordinary meetings and clinical evenings included the presentation of 43 scientific papers and several reports of cases, together with the exhibition of numerous specimens and a number of lantern demonstrations. One meeting was appropriated to the subject of ionic medication, in which members of the Electrical Association of Australia, New South Wales Section, took part; another to a discussion on "The Value of X-rays in Gastro-intestinal Cases"; and another to a lecture, with lantern demonstration, by Dr. A. W. Campbell, on "Cerebral Tumours"; another to midwifery; another to the subject of hospital construction, which members of the New South Wales Institute of Architects and other architects assisted in discussing; and another to the work of military orthopaedic hospitals. One of the clinical evenings was held at the Sydney Hospital.

Representation.—The Branch was represented as follows:

- Council, British Medical Association: Dr. C. J. Martin (Lister Institute).
- Representative Body: Dr. J. Adam Dick (Representative); Dr. W. Chisholm (Deputy Representative).
- Federal Committee of the British Medical Association in Australia: For the year 1918—Dr. G. H. Abbott and Dr. F. P. Sandes; for the year 1919—Dr. F. P. Sandes and Dr. R. H. Todd.
- Australasian Medical Publishing Company, Limited: Dr. W. H. Crago, Dr. R. H. Todd, Dr. F. P. Sandes.
- Council of the New South Wales Bush Nursing Association: Dr. A. A. Palmer.
- Vocational Training Committee of the Repatriation Department: Dr. George Armstrong, Dr. W. H. Crago, Dr. R. Gordon Craig, Dr. R. H. Todd.

Council.—The attendance of Members of the Council and of the Standing Committees of the Council at Meetings was as set out in the table below:—

	Council.	Executive and Finance Committee.	Ethics Committee.	Organization and Science Committee.	Medical Politics Committee.	Medical Journal Sub-Committee (Exec. and Fin. Com.)
	(11)	(12)	(12)	(12)	(16)	(12)
Dr. G. Armstrong	6	10	..	..	..	..
Dr. A. J. Aspinall	9	..	..	11	..	..
† Dr. C. B. Blackburn (Vice-President)	0	0	..	0	0	..
* Dr. F. Barrington	2	..	3½	..	..	..
Dr. A. J. Brady	8	..	9	..	..	..
Dr. W. H. Crago (Hon. Treasurer; Premises Attorney)	7	12	6	5	12	12
Dr. R. Gordon Craig	10	11	..	..	12	8
Dr. A. Davidson	11	..	11	12	..	..
† Dr. J. Adam Dick	0	..	..	..	..	..
Dr. Sinclair Gillies	8	9	8	..	..	..
Dr. Sydney Jamieson (Hon. Librarian)	6	8	..	..	..	..
Dr. C. H. E. Lawes	9	..	..	..	13	..
Dr. T. W. Lipscomb	9	..	..	..	16	..
Dr. W. F. Litchfield (Hon. Medical Secretary)	9	..	..	11½	..	..
Dr. A. A. Palmer (President)	9½	11½	11	2	13	10½
Dr. F. P. Sandes (Acting Vice-President)	8	6	2	2	14½	7
Dr. S. A. Smith	9	..	..	..	15	..
Dr. D. Thomas	6	7	..	..	9	..
Dr. R. H. Todd (Hon. Secretary)	8	10	10	10	12	10
† Dr. R. B. Wade	3	..	7	4	..	..

† Absent for part or all of the year on military service.

* Absent on leave, January to December, 1918.

‡ Chairman.

The Representatives of the Local Associations of Members appointed on the invitation of the Council to attend the regular Quarterly Meetings of the Council were as follows: Dr. A. Maitland Gledden (City), Dr. G. H. Walton Smith (Eastern Suburbs), Dr. H. Browne (Western Suburbs), Dr. E. A. R. Bligh (Northern Suburbs), Dr. H. C. Rikard Bell (South Sydney), Dr. J. J. Hollywood (Central Northern), Dr. J.

Kearney (Central Western), Dr. W. A. H. Burkitt (Central Southern), Dr. H. Busby (Western), Dr. L. E. Ellis (Northern District), Dr. F. C. S. Shaw (Southern District), Dr. S. S. Shirlow (Balmain District), Dr. W. J. White (Illawarra Suburbs).

B.M.A. Building.—Dr. W. H. Crago has continued his valuable services as the Attorney of the Branch for the manage-

ment of the British Medical Association Building, 30-34 Elizabeth Street.

The Library.—Dr. Sydney Jamieson kindly accepted the office of Honorary Librarian and gave careful attention to the duties of the position. Progress has been made in the binding of journals and some extra shelving has been provided, which will facilitate the arrangement of the books.

Affiliated Local Associations of Members.—The following is a list of the Affiliated Local Associations of Members and the names of their Honorary Secretaries:—

Balmain District: Dr. C. U. Carruthers, Balmain.
 Border: Dr. R. Affleck Robertson, Albury.
 Central Northern: Dr. H. G. Allen, Newcastle.
 Central Southern: Dr. G. A. Buchanan, Goulburn.
 Central Western: Dr. E. Cuthbert Hall, Parramatta.
 City: Dr. C. E. Corlette, 175 Macquarie Street.
 Eastern District: Dr. F. O. Stokes, Taree.
 Eastern Suburbs: Dr. F. G. N. Stephens, Rose Bay.
 Illawarra Suburbs: Dr. W. J. White, Kogarah.
 North-Eastern: Dr. R. V. Graham, Lismore.
 Northern District: Dr. E. W. Buckley, Tamworth.
 Northern Suburbs: Dr. E. A. R. Bligh, North Sydney.
 South-Eastern: Dr. J. L. Park, Corrimal.
 Southern District: Dr. W. W. Martin, Wagga Wagga.
 South Sydney: Dr. J. Hoets, Glebe.
 Western Suburbs: Dr. J. F. Walton, Summer Hill.
 Western: Dr. J. T. Paton, Orange.

Annual Meeting of the Delegates of the Local Associations of Members with the Council.—The Seventh Annual Meeting of the Delegates of the Affiliated Local Associations of Members with the Council was held on Friday, October 4, 1918, at the B.M.A. Library, Sydney. The delegates were as follows: Dr. A. M. Gledden (City), Dr. F. G. N. Stephens (Eastern Suburbs), Dr. W. T. J. Newton (Western Suburbs), Dr. E. A. R. Bligh (Northern Suburbs), Dr. W. C. McClelland (Dr. W. F. Litchfield, substitute), (South Sydney), Dr. S. S. Shirlow (Balmain District), Dr. R. Affleck Robertson (Border), Dr. J. J. Hollywood (Central Northern), Dr. G. A. Buchanan (Central Southern), Dr. R. M. Crookston (Central Western), Dr. W. J. White (Illawarra Suburbs), Dr. T. J. Heary (North-Eastern), Dr. L. E. Ellis (Northern District), Dr. John Kerr (South-Eastern), Dr. W. W. Martin (Southern District), Dr. A. E. Colvin (Dr. A. S. Walker, substitute), (Western). The proceedings of the meeting were published in *The Medical Journal of Australia*, 1918, Vol. II., p. 356.

Contract Practice.—

(a) Friendly Society Lodges.

(1) The approved Common Form of Agreement, which has now been in operation for five years since its introduction (January 1, 1914), has continued to give satisfaction. It has been accepted during the past year by lodges which previously resisted it at Drummoyne, Canterbury, Mascot and Parramatta.

(2) A member, in cross-examination (August 8, 1918) in the District Court, having been reported as testifying that he made distinction in some respects between lodge and private patients, inquiry was made by the Friendly Societies' Association, whether it was to be understood that the Common Form of Agreement contemplated such a distinction. A reply was sent to the effect that the contract in the Common Form of Agreement is made for procuring the best possible medical treatment for members of the Friendly Societies and that no departure from such practice had the endorsement of the Council.

(3) In regard to the question of the application of Clause 5 of the Common Form of Agreement to attendance on friendly society lodge members entitled to compensation or receiving payments under the *Workmen's Compensation Act, 1916*, the Council (April 2, 1918) passed the following resolution, namely:—

"That the following provision of the Common Form of Agreement between Medical Officer and Friendly Society Lodge (Clause 5)—

"The Medical Officer shall give medical attendance . . . in all cases of illness or injury . . . provided that such illness or injury be not occasioned by the negligent act or omission of any person in respect of whom such member is entitled to claim compensation or damages in a court of law"—

is not applicable in every case where the Lodge Member

is a person claiming compensation under the *Workmen's Compensation Act, 1916*, but only in those cases where the Lodge Member is entitled to claim compensation or damages in a Court of Law independently of the provisions of the *Workmen's Compensation Act.*"

(b) Colliery Employees.

A Common Form of Agreement for use in the area of the South-Eastern Medical Association between Medical Officer and Colliery Employees' Medical Committee was drafted and adopted by the Council on April 2, 1918, after prolonged joint consideration by a sub-committee of the Council and the medical officers of the southern collieries. It is understood, however, that, owing to certain difficulties which presented themselves, the colliery medical officers referred to eventually preferred to make arrangements, which it is hoped may be equally advantageous, with representatives of the Illawarra District Australian Coal and Shale Employees' Federation, instead of with the several colliery medical committees.

War Emergency Organization.—

(a) Protection of Practices of Members on Active Service.—

The Rule made by the Association in General Meeting (August 28, 1914) has been kept constantly in view. The Rule reads as follows, namely:—

"With a view to conserving the interests of those members of the Branch who undertake naval or military service during the existing state of war, the rest of the members individually engage—in the event of being called upon to fill their positions or attend their patients—to restore the same to them upon their return to civil practice so far as it may be in their power so to do."

Questions have arisen under it from time to time for consideration by the Ethics Committee. It has also been useful in guiding members where occasion arose for arrangements to be made to protect the interests of a colleague who was abroad or about to go abroad on service; and in some instances it has served as a check upon inconsiderate townspeople, who contemplated importing a medical man from elsewhere to supersede a local practitioner who had been called away in his country's service.

(b) Appointment of Officers for Definite Period of Service.—A suggestion made to the Defence Department that officers should be accepted for definite periods of service was not adopted.

(c) Advertisement of Civil Medical Appointments.—It was arranged with *The Medical Journal of Australia* that no advertisement inviting applications from medical men for appointments should be accepted for insertion in the paper unless the applicants were limited to those who were ineligible for or had been released from military service.

(d) Government Appointments.—The Federal and State (New South Wales) Governments were communicated with, urging that no permanent medical or scientific appointments be made until after the termination of the war. Favourable replies were received from the Department of Home and Territories, from the Prime Minister and from the Premier of New South Wales.

(e) Supply of Home Service Officers.—At the request of the Principal Medical Officer when a shortage of medical officers for home service was threatening, members who had not previously undertaken military service abroad or at home were communicated with and a considerable number of offers of service were received.

(f) Record of Members Rejected for Service.—With a view of a record being kept of members who had been prevented from undertaking naval or military service by reason of their being medically unfit to do so, members who had been rejected for service were invited to inform the Council confidentially of the particulars.

(g) Remuneration of Medical Services Rendered on Behalf of the Repatriation Department.—A memorandum was issued to members under date February 1, 1919, in reference to the proposals of the Repatriation Department of December, 1918 (Circular "L") for the appointment of local medical officers in places where local repatriation committees are formed under the *Australian Soldiers' Repatriation Act, 1917-18*, Section 12, and members were invited by the Council not to make permanent arrangements with the Department for undertaking the duties of the office until further notice, as the proposals were to be considered by the Federal Committee on behalf of all the Branches in Australia at an early date.

Owing to the traffic restrictions occasioned by the pneumonic influenza epidemic, the meeting of the Federal Committee, which was to have been held in Melbourne on February 5, was postponed. In order, however, that the Repatriation Department might not be put to inconvenience, members who had been invited by local repatriation committees to accept positions as local medical officers have been advised to undertake the duties in accordance with the proposals of the Department, but not to make permanent arrangements for the purpose.

(h) Military Work in places where there are Members returned from Active Service.—In accordance with a proposal of the Annual Meeting of the Delegates of the Local Associations, the Council passed a resolution urging that all military work, including examination of recruits, examinations for pensions and similar work, in towns where there are members returned from active service or members who have been engaged in home service military work, should be done by such members.

(i) Removal from Medical Register of Names of Medical Practitioners of Alien Enemy Qualifications.—The Federal Government was approached with a view to all medical men practising in Australia of alien enemy birth and qualification being repatriated, and the State Government with a view to the removal from the Medical Register of the names of all persons registered in virtue of German or Austrian qualifications who were not resident or practising in New South Wales at the commencement of the war and of all persons registered who have been interned as alien enemy subjects or otherwise.

(j) Roll of Honour.—A Roll of Honour and Active Service List have been compiled by the Council, which set forth the names and particulars of New South Wales practitioners, 31 in number, who have been killed or whose death is attributable to their service, and the names and other particulars of those, 621 in number, who have served abroad in the Royal Navy, Royal Australian Navy, Royal Army Medical Corps, Army Medical Corps, Australian Imperial Forces, the Australian Naval and Military Expeditionary Force or other service. It is hoped that a worthy memorial will be established to those who made the supreme sacrifice and conspicuous permanent record made of the names of all those who, in their loyal and devoted service to the Empire, have brought honour and distinction to the medical profession.

(k) Medical Officers' Relief Fund (Federal).—At the instance of the Federal Committee, the Executive and Finance Committee of the Council has been appointed to be the Local Committee of Management of the Medical Officers' Relief Fund (Federal), which has been instituted for the assistance of medical men who have been disabled by their war service and the dependants of those who have died, and, by means of loans, to help those who, by reason of their war service, may require temporary assistance. The Fund is to be vested in three Trustees. The Federal Committee arranged that, for the sake of convenience in administration, all the Trustees should be resident in one State and invited the Council of the New South Wales Branch to nominate them. The Council nominated Dr. W. H. Crago, Dr. George Armstrong and Dr. R. Gordon Craig, who were duly appointed by the Federal Committee.

Legislation.—The only Act of Parliament of special interest to the medical profession has been the (New South Wales) *Venerical Diseases Act*, No. 46, 1918. Like the Acts already in force in Queensland, Western Australia, Victoria and Tasmania, the New South Wales Act provides for compulsory treatment and makes it a legal offence for anyone who is not a legally qualified medical practitioner registered in New South Wales or a person acting under 'the direct instruction of such a registered practitioner, to treat the diseases covered by the Act. The Act imposes novel obligations upon practitioners, with heavy penalties for their non-observance. Co-operation on the part of the medical profession is an essential factor in the effective administration of the Act. The Regulations required to be made under the Act have not yet been published and the Act will not come into operation until a date to be proclaimed.

Regulations.—The following regulations of the Branch were made, namely:—

(a) Circularizing the Medical Profession by Member Intending to practise Specialty:—

"No member shall notify other members of the profession by means of a circular letter or otherwise that he practises or intends to practise in any particular branch of medical science. Provided that this restriction shall not apply in the case of a member who does not undertake the immediate care of patients, that is to say, who does not attend patients except on behalf of or in consultation with the medical attendant of such patient."

—General Meeting, June 14, 1918.

(b) Representation of the New South Wales Branch in the Representative Body of the British Medical Association (B.M.A. Articles, 28-30; By-laws 33-40).—The existing regulation was amended to read as follows:—

A representative of the New South Wales Division-Branch in the Representative Body shall be elected annually at a general meeting held not more than nine months nor less than four weeks before the date fixed for the Annual Representative Meeting.

At the same meeting there may be elected also a deputy, with authority to act generally in the place of the representative at any Representative Meeting in the event of the representative being unable or unwilling to attend such meeting, and such deputy may be one out of several members of the Association nominated by way of succession. If no deputy shall have been elected at such meeting, a deputy with authority to act in the place of the representative (in the event aforesaid), at any specified representative meeting or meetings, may be elected at any time before the holding thereof by the President with the advice of the Council."

Constitution.—An important memorandum of the British Medical Association Council, dated January, 1918, dealing with the relationship of the overseas Branches and the parent Association, was received and considered. It was dealt with by the Federal Committee at its meeting held on August 7, 1918 (see *The Medical Journal of Australia*, 1918, Vol. II, p. 168), and a reply on behalf of all the Branches in Australia was sent. It is anticipated that the Constitution will be so amended as to allow of the organization of the Association throughout the Empire to be strengthened.

Australasian Pharmaceutical Formulary.—At the request of the Pharmaceutical Society of New South Wales, the following members, namely, Dr. A. E. Mills, Dr. C. E. Corlette, Dr. T. W. Lipscomb, together with the Honorary Secretary, were appointed a sub-committee to co-operate with the Pharmaceutical Society of New South Wales in the issue of a fresh "Australasian Pharmaceutical Formulary." Meetings were held and progress has been made in the work.

Professional Secrecy.—A member asked for advice in regard to a request by a life assurance company, accompanied by a cheque for £1 ls. by way of fee, to disclose professional secrets of a patient after the patient's death. A reply was given to the effect that the rule of the profession forbidding the disclosure of professional secrets held good, although the patient was dead.

Australasian Town Planning Conference, Brisbane.—On the invitation of the Queensland Government and on the proposal of the Inter-State President (the Honourable J. D. Fitzgerald, M.L.C.), Dr. A. E. Mills and Dr. R. Gordon Craig were appointed delegates of the Association to attend the Australasian Town Planning Conference held at Brisbane, July 26 to 31, 1918.

Hospitals.—

(a) Local Government of Hospitals.—A report (June, 1916) of the Local Government Association of New South Wales, recommending that the government of hospitals be entrusted to municipal and shire councils, under a system similar to that in operation for some years in New Zealand, was considered; and the proposal was not approved. The following opinions expressed by the Council were communicated to the Government, viz.:—

"(1) That the Council does not approve of the Local Government Association's proposal that the local government system should be applied to hospitals.

"(2) That, having regard to the conditions obtaining in Australia, as distinct from those found in other parts of the Empire or in foreign countries, the Council adopts the view that it is in the interests both of economy and efficiency that—

(a) the system of voluntary State-aided hospitals should be continued and encouraged; and

(b) the control of hospitals by a central body, assisted by a committee of management for each hospital, is to be preferred to municipal or any other purely local control; provided that such central body is free from direct political influence; the functions of such central body being (1) to administer the Government grant; (2) to classify hospitals; (3) to prevent overlapping of hospital work; (4) to insist on inquiry for the prevention of imposition; (5) to insist on uniform methods of keeping accounts; (6) to close unnecessary hospitals; (7) to prevent the establishment of unnecessary hospitals; (8) to foster economy in hospital administration; (9) to promote the transfer of patients from one class of hospital to another.

"(3) That the Council is of opinion that, apart from hospitals for mental and infectious diseases, whether hospitals are established and maintained entirely by the gifts of the benevolent or partly by such gifts and partly by public money, or entirely by the expenditure of public money, howsoever derived, they should be used primarily for the benefit of the sick poor."

A reply was received from the Under Secretary of Public Health, advising that the Cabinet had decided negatively in respect of local government of hospitals.

(b) Relation of Member of the Visiting Staff of a Hospital to the Medical Attendant of Hospital Patient.—In accordance with the suggestion of the Annual (1918) Meeting of Delegates of local Associations, the Council passed a resolution as follows:—

"That in the case of a patient being sent into a hospital by his medical attendant and requiring further

treatment after leaving the hospital, the member of the hospital staff who had attended the patient in the hospital should, as far as practicable, in the first instance, refer the patient to the medical man in attendance at the time of going into the hospital."

Pneumonic Influenza Epidemic.—At the request of the Minister of Public Health, the Hon. J. D. Fitzgerald, M.L.C., the Council on November 25, 1918, appointed the following twelve members of the Branch to be a "Consultative Council" to re-inforce Dr. Paton and the Health Department in devising measures to combat the epidemic of influenza, namely: Dr. A. J. Aspinall, Dr. R. Gordon Craig, Dr. Sinclair Gillies, Dr. Sydney Jamieson, Dr. C. H. E. Lawes, Dr. T. W. Lipscomb, Dr. W. F. Litchfield, Dr. A. E. Mills, Dr. A. A. Palmer, Dr. S. A. Smith, Dr. D. Thomas, Professor D. A. Welsh. The following additional members were appointed subsequently, namely: Dr. W. G. Armstrong and Dr. Eric Sinclair.

Education Department: Inspection of School Children.—Arrangements were made with the Principal Medical Officer of the Education Department that the Department notify the Council of the districts in which medical inspection of the schools is to be done, and that the Council communicate with the members practising in the locality, inviting them to take a sympathetic interest in the work, and, with the consent of the parents of the children coming to them for treatment, to give the Principal Medical Officer any information in regard to the treatment that they may care to give. It is thought that this procedure is in the public interest.

Federal Committee.—The Federal Committee of the British Medical Association in Australia met in Sydney, August 7, 1918. The meeting convened for February 5, 1919, to be held in Melbourne, was postponed owing to the traffic restrictions brought into operation in connexion with the pneumonic influenza epidemic. A report of the proceedings of the Sydney meeting was published in *The Medical Journal of Australia*, 1918, Vol. II, p. 168.

A. A. PALMER, President.

Financial Statement.

The Honorary Treasurer, Dr. W. H. Crago, moved that the financial statement as follows be received.

BRITISH MEDICAL ASSOCIATION.

(NEW SOUTH WALES BRANCH.)

Receipts and Expenditure for the Year ended December 31, 1918.

	f	s.	d.		f	s.	d.
Jan. 1, 1918—				British Medical Association	1,059	9	0
Balance Forward	321	12	5	<i>The Medical Journal of Australia</i>	1,016	0	0
Subscriptions	3,463	9	0	Premises Account	300	0	0
Interest Received	25	1	0	Clerical Assistance	747	5	0
Exchange and Discounts	£7	15	9	Assistant Librarian	65	0	0
Less Bank Charges	6	12	6	Printing and Stationery	98	12	11
				Postage and Receipt Stamps	89	18	1
Sales, Common Form of Agreement				Rent	£150	0	0
				Less Sublettings	28	13	0
				Travelling Expenses	121	7	0
				Telephone	29	3	6
				Attendance at Meetings	16	13	9
				Federal Committee	22	17	6
				Bookbinding	27	19	0
				Protectograph	23	5	6
				Sundries	12	13	6
				Balance—	57	0	2
				Cash Book	£127	8	6
				Petty Cash	1	11	0
					128	19	6
					£3,816	4	5

Examined and found correct.

A. MAITLAND GLEDDEEN }
FRED. HALL } Auditors.

11th March, 1919.

W. H. CRAGO,
Hon. Treasurer.

Dr. Crago also referred to the Premises Account and stated that the Auditors, Messrs. L. S. Drummond & Company, had issued a very satisfactory report. The net profit for the year was the highest they had yet attained and stood at £656 13s. 1d. The sum of £3,100 13s. 2d. had been received as rent. Among the items of expenditure there was the sum of £1,155 12s. 6d. paid as interest on the mortgage and on debentures. Wages, rates and taxes, repairs and insurance had absorbed over £1,000. Dr. Crago read the chief items from the Balance Sheet and demonstrated that the undertaking with in a very healthy condition.

Dr. Crago moved a vote of thanks to the Honorary Auditors, Dr. F. W. Hall and Dr. A. Maitland Gledden, for their valuable services.

Presidential Address.

Dr. A. A. Palmer, the President, read his address (see page 271).

Dr. F. P. Sandes asked the members to thank the President for his address. He stated that it was not usual for the mover of a vote of thanks to indulge in criticism of the President's address. He would wish to point out, however, that Dr. Palmer had put his finger on the problem which would be of the greatest concern to the profession in the near future. The reference to the Consultative Council and its relation to the Government was most timely. It was necessary that medical men serving as advisers to the Government should preserve their independence and should give their advice in a fearless manner. The medical profession was not guided by political expediency, but arrived at its conclusions from a consideration of facts.

In regard to the question of nationalization, he thought that Dr. Palmer's remarks were worthy of careful consideration. The whole problem was of great and immediate concern to the profession. He would wish to point out that Dr. Palmer had been most insistent on the necessity of giving returned men a fair deal.

The vote was carried by acclamation.

Election of President, Vice-President and Members of the Council.

The President announced the result of the election of the President, Vice-President and Members of the Council for the ensuing year.

President: Dr. F. P. Sandes.

Vice-President: Dr. C. B. Blackburn.

Members of Council: Dr. George Armstrong, Dr. F. Barrington, Dr. A. J. Brady, Dr. W. H. Crago, Dr. R. Gordon Craig, Dr. Andrew Davidson, Dr. J. A. Dick, Dr. Sinclair Gillies, Dr. Sydney Jamieson, Dr. C. H. E. Lawes, Dr. T. W. Lipscomb, Dr. W. F. Litchfield, Dr. W. C. McClelland, Dr. A. A. Palmer, Dr. S. A. Smith, Dr. D. Thomas, Dr. R. H. Todd and Dr. R. B. Wade.

A vote of thanks was conveyed to the scrutineers, Dr. Archie Aspinall, Dr. A. J. Spiller-Brandon, Dr. J. G. Edwards, Dr. A. J. Gibson, Dr. A. Maitland Gledden, Dr. H. Seaward March and Dr. John Harris.

Dr. W. H. Crago moved and Dr. David Thomas seconded that Dr. F. W. Hall and Dr. A. Maitland Gledden be elected Auditors for the ensuing year. In announcing the result of the election, Dr. Palmer called attention to the fact that Dr. W. H. Crago had come out at the top of the poll. Dr. Crago had been elected a member of the Council for 31 consecutive years.

One the motion of Dr. C. W. Lipscomb, supported by Dr. Sydney Jamieson, it was resolved that Dr. W. Chisholm be appointed the Representative of the Branch in the Representative Body of the British Medical Association for the year 1919-1920 and that Sir Neville Howse be appointed Deputy Representative.

Medical Benevolent Fund of New South Wales.

In the absence of Sir Herbert Maitland, Dr. R. H. Todd presented the Balance Sheet of the Medical Benevolent Fund.

Dr.	The Treasurer in Account with the New South Wales Benevolent Fund.					Cr.		
		£	s.	d.		£	s.	d.
1918—					1918—			
Balance Brought Forward from March 31, 1918	142	2	1		Bank Fees		10	0
Subscriptions from March, 1918, to March, 1919	2	1	0		Bank Exchange			1 6
					Balance as per Pass Book	£146	14	1
					Less Cheque to Sir Herbert Maitland for Cash Paid out of his own Pocket		3	2 6
							143	11 7
							£144	3 1
		£144	3	1				
At Deposit in Savings Bank of N.S.W., Barrack Street, as per Pass Book, Plus Interest to June 30, 1918						322	16	11
Balance at Credit Current Account Commercial Banking Co., of Sydney, Bathurst Street Branch, as per Pass Book						143	11	7
Total Credit						£466	8	6

H. E. Maitland,
Secretary.

Audited and found correct,

ARCHIE ASPINALL.

He also moved that the following be the office-bearers of the fund for the year 1919-1920:—

Trustees: Dr. Robert L. Faithfull and Dr. F. W. Hall.

Honorary Secretary: Sir Herbert Maitland.

Honorary Treasurer: Dr. R. L. Faithfull.

Members of the Committee: Dr. F. W. Hall, Dr. J. M. Gill and Dr. T. Fiaschi.

Induction of President.

Dr. A. A. Palmer then introduced Dr. F. P. Sandes as President of the Branch. He pointed out that the bulk of the work necessarily fell on the Honorary Secretary and Treasurer, but there was usually one man who undertook more work than the remainder of his colleagues. He assured the meeting that this applied to Dr. Sandes. In regard to the question of the nationalization of the profession, Dr. Sandes had drafted one scheme—he was not sure that there were not several—for the consideration of the Council. He was sure that Dr. Sandes would be a very valuable President,

Dr. Sandes thanked Dr. Palmer for the nice things he had said and thanked the members for having elected him to a post of honour and trust. He promised to do what he could and hoped that things would go on as smoothly during his period of office as they had during the year when Dr. Palmer was President.

MEDICO-POLITICAL.

An extraordinary general meeting of the New South Wales Branch was held at the B.M.A. Rooms, 30-34 Elizabeth Street, Sydney, on March 28, 1919, Dr. F. P. Sandes, the President, in the chair.

Medical Ethics.

Dr. R. H. Todd, the Honorary Secretary, moved the following, on behalf of the Council:—

(a) That no member shall be a party, whether on payment of subscriptions or otherwise, to the appearance of his name in a "local hanging-card directory"

or other similar directory to be displayed for advertisement purposes.

- (b) That no member shall permit or be a party to the publication of his name in any "return thanks" notice in a newspaper.
- (c) That, except with the express sanction of the Council, no member shall have a consulting room in a chemist's shop.

The motions were duly seconded and carried.

Friendly Society Lodges.

Dr. T. W. Lipscomb moved on behalf of the Council the following additions to the regulation governing the contract attendance on friendly society lodge patients.

- (1) No member shall meet any deputation of friendly society lodge members in regard to the Common Form of Agreement between Medical Officer and Friendly Society Lodge without the consent in writing first had and obtained of the committee of the local association of members.
- (2) When a member has been approached by a friendly society lodge to accept appointment as a medical officer he shall apply in the first instance to the Honorary Secretary of the local association of members and forward to him the letter of application received from the lodge.

The motions were duly seconded and were carried.

A further resolution was passed modifying a regulation by the substitution for a contract medical benefit certificate of a declaration to the following effect:—

I do solemnly declare that my total income together with that of my wife from all sources does not exceed £208 per annum, and that I understand that, if at any time hereafter my total income, together with that of my wife, from all sources exceeds £312 per annum, I shall thereupon cease to be entitled to services of the medical officer.

Medical Officers' Medical Relief Fund.

Dr. W. H. Crago said that he wished to make a few remarks concerning the Medical Officers' Relief Fund. He called attention to the fact that the Federal Committee had dealt with this subject at its meeting of August 7 and 8, 1918, and had passed the following resolutions:—

- (1) That a Federal Fund be established by donations from members of the profession in all the States.
- (2) That it be vested in Trustees appointed by the Federal Committee.
- (3) That a local Committee of Management be appointed by the Branch Council in each State to consist of three members of the British Medical Association.
- (4) That the Fund shall be used in assisting medical officers who have been disabled and the dependants of those who have died.
- (5) That the Fund shall also be used to issue loans with or without interest to medical men who, on account of war service, may require temporary financial assistance.
- (6) That to create the Fund, an effort be made in each State to secure at once as large initial individual donations as possible, or annual contributions.

Dr. Crago reminded the members that these propositions had been accepted by the New South Wales Branch and that the Executive and Finance Committee had been asked to act as Local Committee for the purpose of the Fund. The Federal Committee had requested the New South Wales Branch Council to nominate three members to act as Trustees. It was recognized that it would be distinctly disadvantageous if the Trustees were not resident in one State. The Branch Council had nominated Dr. George Armstrong, Dr. R. Gordon Craig and himself. He proceeded to read a letter from Dr. W. T. Hayward, C.M.G., the Chairman of the Federal Committee, dated January 15, 1919, appointing Drs. Armstrong, Craig and himself Trustees of the Fund.

There had been delay in getting the matter started. He regretted this, but said that they had been careful in endeavouring to get a good start. He thought that the time had now arrived when something should be done. The Trustees had experienced great difficulty in estimating the amount of money that would be required. Dr. Todd had collected information from the other Branches concern-

ing the number of those who had been on active service. This had been useful in forming a working estimate. He was afraid that a very large sum would be required. The sum of £50,000 had been mentioned. Dr. Crago expressed the hope that the response would be generous. He ventured to look for contributions of £50 or £100 from some of the well-established members. The local committees in each State would soon appeal for donations.

Dr. R. Gordon Craig said that a considerable number of medical officers had been disabled or wounded and would not be able to carry on their practices in the same way as they had before they had gone overseas. These men would need assistance. They had also to remember their obligations to the men who had paid the full penalty; their dependants must not be forgotten. Others would also require financial help to start them on their way. A suggestion had been made that the Medical Officers' Relief Fund should hand to the Repatriation Department guarantees to cover loans to medical men to enable them to re-establish themselves in practice. Dr. George Armstrong, Dr. Crago and he had considered this proposal and had come to the conclusion that it was wholly unsatisfactory. They must have money in hand and it would be a great mistake to speculate on promises. It was realized that if a practitioner agreed to guarantee a certain sum, he might be unable to meet his obligation at some future date, when called upon to pay up. The Trustees had come to the conclusion that nothing short of £50,000 would suffice. It was a large amount of money. But large sums were required for this purpose. He illustrated this point by referring to the widow of a medical man who had been killed in the war. She was receiving from the Repatriation Department a pension that enabled her to keep the wolf from the door. She had to live very differently from the way she had been accustomed to live. And yet her pension represented the interest on the capital sum of £4,000. It was obvious that they would all have to give liberally and freely.

There was one matter to which he wished to refer. The Trustees had to decide whether the subscriptions should be confined to those who had not been able to serve their country, or whether men who had joined the Australian Army Medical Corps for service abroad, should be allowed to help. He felt that the financial sacrifice that some of the men who had gone overseas, had not been so great that they could not well afford to give to the fund, and he was convinced that these men would wish to contribute. In conclusion he expressed the hope that the members would use their influence with their friends and colleagues to give as much as they could, either as cash down or distributed over a number of years.

Dr. Archie Aspinall was pleased to learn that Dr. Gordon Craig was in favour of allowing returned men to contribute to the fund. He agreed with Dr. Craig that many of those who had served, would wish to give something. He called attention to the Federal nature of the fund. The war had awakened a Federal spirit and he hoped that this fund would be allowed to encourage it. It should not be divided up into six State funds, but the Federal nature of the fund should be preserved.

Dr. R. H. Todd recounted the results of his enquiries concerning the number of men who had served. He had written to the Honorary Secretaries of the other Branches and had received the information he had sought. The numbers were probably not quite accurate as several medical men had enlisted in States other than those in which they resided and consequently there was some overlapping. The figures were as follows:—

	Number of Men Who Had Served.	Members of the B.M.A.
New South Wales	621 ..	452
Victoria	537 ..	353
Queensland	150 ..	140
South Australia	130 ..	109
Western Australia	71 ..	54
Tasmania	26 ..	17

He pointed out that many men joined immediately after graduating and consequently they had not yet become members of the British Medical Association.

In dealing with the amount required, he found that he had arrived at the same estimate as the Trustees had.

While he could not give any definite reasons for arriving at the conclusion that £50,000 would be required, it was significant that he had made this estimate independently. As far as New South Wales was concerned he had calculated that the proportion to be raised in the State was £22,000. The Branch had approximately 1,100 members, and he assumed that they would have to look to about 700 members for the contributions. In other words, the average contribution would have to be £30 to £33. It was, of course, to be expected that some would give large amounts and others would give small ones. He referred to the necessity of obtaining permission to start the fund and expressed the hope that this would not involve much delay.

Dr. Gordon Craig again addressed the meeting. He wanted to point out that a considerable sum of money might eventually remain in the hands of the Trustees and that they would have to decide what should be done with this money. He made the suggestion that a research scholarship might be founded out of the surplus. He claimed that the medical profession in Australia was not contributing a due proportion to science, as compared with the other parts of the world. He thought that Australian medicine was more or less parasitic on the other countries in regard to science, but he was not prepared to attribute this to any want of ability or ingenuity on the part of Australian students. He hoped that with the increased opportunity for original research, Australia would come to occupy her proper place among the nations. The suggestion was thrown out as a practical means of dealing with an ultimate surplus.

The undermentioned have been nominated for election as members of the New South Wales Branch:—

Walter Watson Feather, Esq., M.B., Ch.M. (1919, Univ. Sydney), 28 St. George's Crescent, Drummoyne.
 Idris Morgan, M.B. (1915, Univ. Sydney), Commercial Bank Chambers, Hunter Street, Newcastle.
 William Thomas Nelson, Esq., M.B., Ch.M. (1918, Univ. Sydney), Sydney Hospital, Sydney.
 Bernard Hillard Simon, Esq., M.B., Ch.B. (1916, Univ. Edin.), 69 Johnston Street, Annandale.

The undermentioned have been elected members of the New South Wales Branch:—

Cyril Charles Minty, Esq., M.B. (1915, Univ. Sydney), 458 Miller Street, North Sydney.
 Howard Kynaston Denham, Esq., M.B., Ch.M. (1915, Univ. Sydney), Grosvenor Crescent, Summer Hill.
 Albert Arcsott Pain, Esq., M.B., Ch.M. (1918, Univ. Sydney), Chapel Street, Marrickville.
 Arthur Duncan Forbes, Esq., M.B. (1913, Univ. Sydney), Bank of Queensland, Limited, George Street, Sydney.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending March 22, 1919:—

	Metropolitan District.	Hunter River District.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever ..	3 0 ..	3 0 ..	16 0 ..	22 0
Scarlatina ..	6 1 ..	0 0 ..	8 0 ..	14 1
Diphtheria ..	27 0 ..	13 0 ..	53 1 ..	93 1
*Pul. Tuberculosis ..	17 13 ..	1 0 ..	4 1 ..	22 14
Poliomyelitis ..	1 0 ..	0 0 ..	0 0 ..	1 0
Malaria ..	2 0 ..	0 0 ..	0 0 ..	2 0
P'monic Influenza ..	133 9 ..	31 0 ..	1 1 ..	165 10

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending March 23, 1919:—

	Metropolitan.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever ..	2 0 ..	13 0 ..	15 0
Scarlatina ..	8 0 ..	22 0 ..	30 0
Diphtheria ..	53 2 ..	51 1 ..	104 3
Pulmonary Tuberculosis ..	15 7 ..	10 1 ..	25 8
Influenza ..	466 24 ..	54 8 ..	520 32

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending March 22, 1919:—

Diseases.	No. of Cases.
Enteric Fever ..	27
Scarlatina ..	1
Diphtheria ..	54
Pulmonary Tuberculosis ..	6
Erysipelas ..	2
Anchylostomiasis ..	1
Poliomyelitis ..	2
Puerperal Fever ..	1
Pneumonia ..	22

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, during the week ending March 15, 1919:—

	Adelaide.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever ..	0 1 ..	1 1 ..	1 2
Scarlatina ..	2 0 ..	21 0 ..	23 0
Diphtheria ..	1 0 ..	14 1 ..	15 1
Pulmonary Tuberculosis ..	1 1 ..	7 4 ..	8 5
Erysipelas ..	0 0 ..	1 0 ..	1 0
Morbili ..	0 0 ..	7 0 ..	7 0
Pertussis ..	0 0 ..	12 0 ..	12 0
Influenza ..	1 0 ..	1 0 ..	2 0
Influenza Vera ..	0 0 ..	1 0 ..	1 0
Puerperal Fever ..	0 0 ..	1 0 ..	1 0
C'bro-Spinal Meningitis ..	1 0 ..	1 0 ..	2 0

NEW ZEALAND.

The following notifications have been received by the Chief Health Officer, Department of Public Health, Hospitals and Charitable Aid, New Zealand, for the four weeks ending March 17, 1918:—

Diseases.	No. of Cases.
Scarlatina ..	66
Diphtheria ..	184
Enteric Fever ..	31
Pulmonary Tuberculosis ..	89
Poliomyelitis ..	2
Cerebro-Spinal Meningitis ..	3
Puerperal Fever ..	6
Erysipelas ..	5
Ophthalmia Neonatorum ..	2
Influenza ..	100
Morbili ..	13
Hydatids ..	2
Septicæmia ..	1

MEDICAL INSPECTION OF SCHOOL CHILDREN IN QUEENSLAND.

In the annual report of the Secretary for Public Instruction in the State of Queensland for the year 1917 the subject of medical inspection is dealt with in a somewhat unusual manner, owing to the fact that the Chief Medical Inspector of Schools, Dr. Eleanor Bourne, and the Assistant Full-time Medical Inspector, the late Dr. Elizabeth Sweet, were both absent from the State on military duty. It is pointed out that the requirements of the military authorities rendered it impossible to strengthen the then existing staff and that in consequence the administration of the system of medical inspection had been considerably affected.

During the year 1917 the work of medical inspection was performed by thirteen part-time medical inspectors. There were three in the Brisbane district and one in each of the following districts, Cairns, Charters Towers, Gympie, Ipswich, Mackay, Maryborough, Mount Morgan, Rockhampton, Toowoomba and Townsville. These inspectors visited the schools in their respective districts once each week. It appears that two days a week were devoted to this work. A rapid inspection was carried out of each child on entering the school. A thorough examination was undertaken as each child reached the age of nine years and a further inspection took place of the pupils before they left school. Children who were found to be defective at the first inspection or thorough examination, were re-examined at a subsequent visit of the medical inspector. Special examinations were carried out at the request of the teachers or school nurses. The medical inspectors gave advice in regard to the physical fitness for different kinds of work of the children leaving school, and, in certain circumstances, in regard to the choice of employment. They were also required to act during the progress of an epidemic, both in regard to the questions of excluding pupils or of closing the school and also in regard to the institution of special examinations of the pupils. Each year a report was submitted concerning the hygienic conditions of the school buildings and grounds.

Under ordinary circumstances, four school nurses are employed to assist the medical inspector to undertake following-up work and to instruct parents and children in regard to the rules of healthy living. During the year 1917 one of the school nurses was absent on military duty. The work was therefore conducted by three nurses.

The total number of visits paid by the medical inspectors was 750. No less than 20,071 medical examinations were carried out. The number of children reported to be suffering from physical defects was 5,078. Unfortunately, no further details are given, as the usual special reports of the medical inspectors have been omitted for the year, for the reason stated above.

The Department has been unable to appoint an ophthalmic inspector of school children to continue the excellent work which the late Dr. Douglas Rodger instituted in 1912. It will be remembered that Dr. Rodger joined the Royal Army Medical Corps in 1915 and was killed in action on July 1, 1916. In 1917 efforts were made to control the incidence of trachoma and to minimize its effects by arranging with the medical officers of the local hospitals to examine every child with affections of the eyes and to undertake treatment in all cases of inflammatory changes. The medical practitioners are paid from £50 to £75 per annum for this work. It is impossible to estimate the success of this arrangement, as no technical data are published.

The report also contains reference to the dental work undertaken by the chief dental inspector and the five assistant dental inspectors. The work is carried out in Brisbane and in the Ipswich district. The total number of children examined was 16,594. Of these, 2,281, or approximately 13.7%, had dirty mouths. The number of teeth treated was 18,226. In more than half the instances the carious tooth had to be extracted. Gratuitous treatment is given at the Brisbane Dental Hospital to all children of parents whose income does not exceed £156 a year or £30 per year per member. Outside the metropolitan area gratuitous treatment is given to all children in those districts in which there is no resident or visiting dentist, while in other districts gratuitous treatment is accorded, as in Brisbane. The Chief Dental Inspector publishes a special report dealing with the result of the year's work.

Correspondence.

THE EFFICIENCY OF MEDICAL PRACTITIONERS.

Sir,—Some six years ago I had the advantage of a course of post-graduate work in London. A large number of the hospitals in London were open to graduates and in a number special post-graduate courses were provided. Amongst the men attending these classes I made the acquaintance of doctors from all parts of Great Britain, North and South America, South Africa, Egypt, Persia, India, China and

even missionaries from Africa. Naval men and others in various branches of the Government service also attended.

Our universities in Australia could with advantage follow the methods of the Edinburgh University in regard to post-graduate work. In Edinburgh during the summer vacation a course of post-graduate instruction was given, *viz.*, a course on diseases of children during the last two weeks of July, a medical course during the whole of the month of August and in September courses in practically all branches of our profession. It is high time that something of this kind was instituted in one of our Australian universities, as such a procedure would be in keeping with methods now ruling in centres of any importance and would be of advantage not only to the graduate but also to his patients. Owing to the hot weather in Sydney during the summer vacation, perhaps a course of instruction might be arranged for the month of June at, say, the Sydney Hospital.

Yours, etc.,

"NEVER TOO LATE TO LEARN."

March 25, 1919.

THE PROPHYLAXIS OF VENEREAL DISEASE.

Sir,—In the issue of your number bearing to-day's date is a letter from Colonel Roth, in which he states: "I believe I was the first to start the prophylactic treatment of venereal disease in the A.I.F. in Australia."

On consulting my diary I find that, as early as November 19, 1914, when I was Medical Officer to the 7th Light Horse Regiment, at that time stationed at Holdsworthy, I obtained a large supply of calomel ointment, 33% strength, for the special purpose of venereal prophylaxis.

On December 5, 1914, a further supply was obtained from the P.M.O. of this District, so that every member of the regiment was supplied with a tube after instructions were given as to their use.

These dates are prior to the formation of the 5th Field Ambulance.

Yours, etc.,

H. FLECKER, Major, A.A.M.C.,

Temora, N.S.W.,

March 29, 1919.

The attention of readers is drawn to an advertisement in another portion of this issue, announcing that Messrs. Backhouse and Goyder, medical agents, have removed their offices from the Mutual Life of New York Building, 14 Martin Place, to the Perpetual Trustee Company's Building in Hunter Street, Sydney.

Books Received.

THE INTENSIVE TREATMENT OF SYPHILIS AND LOCOMOTOR ATAXIA BY AACHEN METHODS (WITH NOTES ON SALVARSAN), By Reginald Hayes, M.R.C.S., etc.; Third Edition; Revised; 1919. London: Baillière, Tindall & Cox; Crown 8vo., pp. 92, illustrated by four plates. Price, 4s. 6d. net.

THE ONE BIG UNION: WILL IT EMANCIPATE THE WORKER, by P. S. Cleary, President of the Catholic Federation; 1919. Sydney: Angus & Robertson, Limited; Post 8vo., pp. 61. Price, 1s.

AN INQUIRY INTO THE MEDICAL CURRICULUM by the Edinburgh Pathological Club, Papers contributed to the Inquiry and Report by the Pathological Club, reprinted from the *Edinburgh Medical Journal*; 1919. Edinburgh: W. Green & Son, Limited; Royal 8vo., pp. 512.

Proceedings of the Australian Medical Boards.

QUEENSLAND.

The following have been registered, under the provisions of *The Medical Act of 1867* as duly qualified medical practitioners:—

Gillies, Henry Vicars, Maryborough, M.B. (Univ. Sydney, 1916).

Jameson, James Ian Munro, Herberton, M.B., Ch.M. (Univ. Sydney, 1914).

SOUTH AUSTRALIA.

The undermentioned has been registered, under the provisions of the *Medical Act, 1880*, as a duly qualified medical practitioner:—

Alan Rabone Fletcher, M.B., Sydney, 1918.

Medical Appointments.

The appointment of Dr. Bertram C. Cohen, Dr. Hans Stubbs and Dr. John Noel Brown as Junior Resident Medical Officers to the Perth Public Hospital is announced in the *Government Gazette of Western Australia* of March 7.

In pursuance of the provisions of *The Medical Act of 1867*, the resignation of Dr. E. S. Jackson (B.M.A.) as a Member and President of the Queensland Medical Board has been accepted.

Dr. G. E. Aitken (B.M.A.) having been promoted, Dr. Richard P. Hill (B.M.A.) has been appointed for twelve months, on probation, Second Assistant Medical Superintendent, Hospital for the Insane, Goodna, Queensland.

Dr. F. G. Connolly has been appointed President and Dr. Andrew Stewart (B.M.A.) a Member of the Queensland Medical Board, in order to fill the vacancies caused by the resignation of Dr. E. S. Jackson (B.M.A.).

His Excellency the Governor of South Australia in Council has appointed Dr. C. V. Wells (B.M.A.) an Honorary Commissioner to enquire into and report upon the prevention and treatment of venereal diseases in Great Britain and the United States of America.

The resignation of Dr. G. V. F. Doyle as a Resident Medical Officer at the Brisbane Hospital has been accepted.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xix.

Department of Public Health, New South Wales: Rookwood State Hospital, Junior Medical Officer.
Newcastle Hospital: Three Resident Medical Officers.

Medical Appointments.**IMPORTANT NOTICE.**

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other Contract Practice. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Cloncurry Hospital.
TASMANIA. (Hon. Sec., Macquarie Street, Hobart.)	Medical Officers in all State-aided Hospitals in Tasmania.

Branch.**APPOINTMENTS.****SOUTH AUSTRALIA.**

(Hon. Sec., 3 North Terrace, Adelaide.)

Contract Practice Appointments at Renmark.
Contract Practice Appointments in South Australia.

WESTERN AUSTRALIA.

(Hon. Sec. 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.)

All Contract Practice Appointments in Western Australia.

NEW SOUTH WALES.

(Hon. Sec., 30-34 Elizabeth Street, Sydney.)

Australian Natives' Association.
Balmmain United Friendly Societies' Dispensary.
Canterbury United Friendly Societies' Dispensary.
Friendly Society Lodges at Casino.
Friendly Society Lodges at Lithgow.
Friendly Society Lodges at Parramatta, Auburn and Lidcombe.
Leichhardt and Petersham Dispensary.
Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney.
Marrickville United Friendly Societies' Dispensary.
New South Wales Ambulance and Transport Brigade.
Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend.
North Sydney United Friendly Societies.
People's Prudential Benefit Society.
Phoenix Mutual Provident Society.

NEW ZEALAND: WELLINGTON DIVISION.

(Hon. Sec., Wellington.)

Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

- Apr. 8.—N.S.W. Branch, B.M.A., Council (Quarterly).
Apr. 10.—Vic. Branch, B.M.A., Council.
Apr. 11.—Q. Branch, B.M.A., Council.
Apr. 11.—S. Aust. Branch, B.M.A., Council.
Apr. 11.—N.S.W. Branch, B.M.A., Clinical.
Apr. 15.—Tas. Branch, B.M.A., Council.
Apr. 15.—N.S.W. Branch, B.M.A., Ethics Committee; Executive and Finance Committee.
Apr. 16.—W. Aust. Branch, B.M.A., Council and Branch.
Apr. 16.—North-Eastern Suburbs Med. Assoc. (N.S.W.) Annual; Eastern Suburbs Med. Assoc. (N.S.W.).
Apr. 17.—City Med. Assoc. (Sydney, N.S.W.).
Apr. 22.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Apr. 24.—S. Aust. Branch, B.M.A.
Apr. 25.—N.S.W. Branch, B.M.A.
Apr. 25.—Q. Branch, B.M.A., Council.
Apr. 30.—Vic. Branch, B.M.A., Council.
Apr. 30.—Western Suburbs Med. Assoc. (N.S.W.).

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.
Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.
All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney.